CENTERS FOR MEDICARE & MEDICAID SERVICES					ON	AB NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMP	LETED
		155115	B. WIN			11/05	5/2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1121 E	LASALLE AVE		
		REHABILITATION CENTER			H BEND, IN 46617		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was State Licensul Survey dates: November 1, 2 Facility number Provider number AIM number:	for a Recertification and re Survey. October 29, 30, 31, 2 and 5, 2012 er: 000048 per: 155115 100275330 y) Vargas, RN-TC , RN e, RN	F00		The creation and submission of this plan of correction do not constitute an admission this provider of any conclusest forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and sever of this survey, the facility respectfully requests a destreview in lieu of a post-survervisit on or after December 2012.	pes n by sion f tition erity k	DATE
	Quality review	11/08/12 by Suzanne					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Williams, RN

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER		H BEND, IN 46617	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	l	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0156	483.10(b)(5) - (1	0), 483,10(b)(1)			
SS=A	, ,, ,	HTS, RULES, SERVICES,			
	CHARGES				
		inform the resident both			
	-	ing in a language that the			
		ands of his or her rights and			
		ulations governing resident			
		consibilities during the stay			
		ne facility must also provide the notice (if any) of the			
		under §1919(e)(6) of the			
		ation must be made prior to			
		on and during the resident's			
	· ·	such information, and any			
	amendments to i	t, must be acknowledged in			
	writing.				
	The facility must	inform each resident who is			
		aid benefits, in writing, at			
		ssion to the nursing facility			
		dent becomes eligible for			
		tems and services that are			
		ng facility services under the			
	•	or which the resident may			
		those other items and facility offers and for which			
		be charged, and the			
		es for those services; and			
		dent when changes are			
		s and services specified in			
	paragraphs (5)(i)	(A) and (B) of this section.			
	The facility must	inform each resident			
		time of admission, and			
	periodically durin	ig the resident's stay, of			
		e in the facility and of			
	•	e services, including any			
		ces not covered under			
	Medicare or by th	ne facility's per diem rate.			
	The facility must	furnish a written description			
	of legal rights wh				
	_		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	NDIC.	00	COMPL	ETED
		155115	A. BUILI B. WING			11/05/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			LASALLE AVE		
CARDINAL NURSING AND REHABILITATION CENTER				BEND, IN 46617			
					DENE, IN 18817		715)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	, n	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	r	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		the manner of protecting		IAG			DATE
		under paragraph (c) of this					
	section;						
	A description of	the requirements and					
		stablishing eligibility for					
		ing the right to request an					
		er section 1924(c) which					
		extent of a couple's purces at the time of					
		n and attributes to the					
		se an equitable share of					
		cannot be considered					
		ment toward the cost of the					
		spouse's medical care in his					
	Medicaid eligibili	f spending down to					
	Medicald eligibili	ty levels.					
	A posting of nam	nes, addresses, and					
		ers of all pertinent State					
		groups such as the State					
		ication agency, the State					
		the State ombudsman tection and advocacy					
		Medicaid fraud control unit;					
		that the resident may file a					
		e State survey and					
		ncy concerning resident					
		and misappropriation of					
		in the facility, and with the advance directives					
	requirements.	mar are deverses directives					
	The facility must	comply with the					
		ecified in subpart I of part					
		er related to maintaining					
	written policies a	nd procedures regarding					
		es. These requirements					
		s to inform and provide					
		on to all adult residents					
		ght to accept or refuse cal treatment and, at the					
	incurca or surgic	our troutinent and, at the					

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
NAME OF P	DOMDED OF GLIDBLES	D.	_	ET ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	PROVIDER OR SUPPLIE	K	1121	E LASALLE AVE	
	AL NURSING AND	REHABILITATION CENTER	SOU	TH BEND, IN 46617	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG		n, formulate an advance	TAG	DEFICIENCY)	DATE
	·	ncludes a written description			
		olicies to implement			
		es and applicable State law.			
	The facility must	inform each resident of the			
		and way of contacting the			
		nsible for his or her care.			
	The feetile :	and the standard of the standa			
		prominently display in the formation, and provide to			
		plicants for admission oral			
	·	mation about how to apply			
		icare and Medicaid benefits,			
		ve refunds for previous			
	Based on reco	ed by such benefits.	F0156	E4EC Nation of Binkts B	12/05/2012
			F0136	F156 – Notice of Rights, Ru Services, Charges It is the	ıles, 12/05/2012
	2 of 3 resident	facility failed to ensure		practice of this provider to in	nform
		the discontinuation of		the resident both in writing a	
		s received notification		a language that the resident	
	prior to the en			understands of his or her rig	
	(Residents #9			and all rules and regulations governing resident conduct	
	(I VESIGEITIS #3	2 and #120j		responsibilities during the st	
	Findings include	de.		the facility. What corrective	
		uo.		action(s) will be accomplis	
	l 1 The form titl	led, "Notice of Medicare		for those residents found to have been affected by the	10
		e" for Resident #99 was		deficient practice: Residen	t #99
	_	1/2/12. The form		 resident and family have be 	
		date the resident's		informed of Notice of Medica	are
				Non-Coverage. This reside	
	Medicare coverage would end was 5/28/12. The form also indicated the			experienced no negative ou related to this finding. Resid	
		led on 5/28/12 to the		#128 – has been discharged	
		onsible party. There		the facility and moved to an	other
		nour notice prior to the		state. The Notice of Medica	
		re skilled services.		Non-Coverage was not prov	
	2 2. 11104104			prior to discharge, but copie were sent to family post	5
	Interview with	the Social Service		discharge. How other resid	dents
			1	i	1

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPLETED	ъ
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	.D
155115 B. WING 11/05/2012	12
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1121 E LASALLE AVE	
CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN 46617	
CARDINAL NORSING AND REHABILITATION CENTER 300 TH BEND, IN 400 TI	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	OMPLETION
	DATE
Director on 11/5/12 at 8:25 a.m., having the potential to be	
indicated Resident #99 was admitted affected by the same deficient	
to the facility on 5/15/12. Her last day	
of Modicare skilled corriges was	
5/28/12. She had 87 days of skilled be taken: All residents receiving Skilled Nursing Services have the	
Medicare services remaining. She potential to be affected by this	
(f. 1) A f. 111	
completed by SSD/designed	
Non-Coverage was to be provided to This audit will ensure all residents	
the resident or to the resident's have been given proper and	
responsible party 48 hours prior to the timely notification for the past 90	
end of Medicare skilled services. She days related to Notice of	
indicated the letter was not provided Medicare Non-Coverage. Any	
to the resident or the resident's errors or omissions noted during	
this audit will be clarified and/or	
responsible party timely. corrected immediately. Changes in residents receiving Skilled	
2. The record for Resident #128 was Nursing Services will be	
reviewed on 11/5/12 at 8:15 a.m The communicated to all responsible	
I staff during daily meetings What I	
resident was admitted to the facility measures will be put into place	
on 5/15/12. She was discharged from or what systemic changes will	
the facility on 6/15/12.	
deficient practice does not	
Interview with the Social Service Private and 14/5/40 at 0.00 area.	
Director on 11/5/12 at 8:20 a.m.,	
indicated the resident had 62 days of other responsible staff members	
skilled Medicare remaining at the time regarding Medicare	
of discharge. There was no evidence Non-Coverage Notifications. This	
that a "Notice of Medicare in-servicing will be completed on	
Non Coverage" was provided to the	
ED/DIVO/designee will review all	
resident or the resident's responsible residents pending discontinuation	
party prior to the end of Medicare of Skilled Services to ensure	
skilled services. notification is provided within 2	
days. How the corrective action(s) will be monitored to	
Interview with the Social Service ensure the deficient practice	
Director on 11/5/12 at 8:20 a.m., will not recur, i.e., what quality	
indicated there was no "Notice of assurance program will be put	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER	SOUTH	I BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		Coverage" provided to		into place: The ED/SSD/designee will be	
	the resident pri	ior to discharge.		responsible for completing the	<u>.</u>
				CQI Audit Tool titled, "Dischar	
	The policy title			Planning" weekly for 4 weeks	and
		ructions for Issuing a		monthly for 6 months. If	_
	Notice of Medi			threshold of 90% is not met, a action plan will be developed.	in
		/Determination On		Findings will be submitted to t	he
	•	y" was provided by the		CQI Committee for review and	
		Director on 11/5/12.		follow up. By what date the	
		the policy was current.		systemic changes will be	
		cated the Notice of		completed: Compliance Date 12/5/12.	
		Coverage form must		12/0/12.	
		ater than two days (48			
	,	he proposed end of			
	services.				
	0.4.4/->				
	3.1-4(a)				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/05/2012
		100110	B. WING		11/00/2012
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F0205 SS=A	to a hospital or al therapeutic leave provide written in and a family mem that specifies the policy under the Swhich the residence the nursing facility bed-hold periods, with paragraph (b permitting a resid At the time of tranhospitalization or nursing facility mu and a family mem written notice whith bed-hold polic (b)(1) of this section based on reconsinterview, the fathe resident's received a copy hold policy upon hospital for 1 or for discharge of met the criteria transfer, and diffusion with a father transfer an	fransfr facility transfers a resident lows a resident to go on , the nursing facility must formation to the resident ober or legal representative duration of the bed-hold state plan, if any, during it is permitted to return and e in the nursing facility, and y's policies regarding which must be consistent o)(3) of this section, ent to return. Insfer of a resident for therapeutic leave, a just provide to the resident ober or legal representative ch specifies the duration of ey described in paragraph on. Indicate the direction of the facility failed to ensure esponsible party y of the facility bed in transfer to the figure 2 residents who for admission, escharge. (Resident	F0205	The creation and submission of this plan of correction do not constitute an admission this provider of any conclus set forth in the statement of deficiencies, or of any violator of regulation. Due to the relative low scope and sever of this survey, the facility respectfully requests a destreview in lieu of a post-surverview in lieu of a post-surverview in the procession or after Decembe 2012.F205 – Notice of Bed-Policy Before/Upon Transferis the practice of this facility the provide written information to resident and a family members.	pes n by sion f tion erity k rey r 5, Hold or It

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NAME OF PROVIDER OR SUPPLE CARDINAL NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES IN THAT IS A STATE AND A	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATIMINT OF DIFFICINCIES (EACH DEPICINCY MUST BE PRECEDED BY FULL REFULL ATORY OR IS CIDENTIFYING PROMATION) They did not recall receiving a copy of the facility's bed hold policy and the policy allowing the resident to return to the facility the last time the resident was transferred to the hospital. The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident was sent to the Emergency room for evaluation and returned to the facility on 5/26/12. Documentation in the Resident progress note on \$5/26/12 at 1:00 p.m., indicated the resident's daughter was present when the resident's daughter received a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy in the resident's chart. Interview with the Social Service Director for the Cottage Unit on 11/5/12 at 10:30 a.m., indicated that he could not find a bed hold form in the resident's family should have received or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of or been mailed a copy of the bed hold of the resident's family should have received or been mailed a copy of the bed hold	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	I DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPFLIER CARDINAL NURSING AND REHABILITATION CENTER OX-DD SUMMARY STATEMENT OF DEFICENCES PREFIX TAG they did not recall receiving a copy of the facility's bed hold policy and the policy allowing the resident to return to the facility bed hold policy and the policy allowing the resident twas transferred to the hospital. The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident was sent to the Emergency room for evaluation and returned to the facility on 5/26/12. Documentation in the Resident progress note on 5/26/12 at 1:00 p.m., indicated the resident's daughter was present when the resident was transferred to the hospital. There was no documentation to indicate if the resident's daughter received a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy in the resident's chart. Interview with the Social Service Director for the Cottage Unit on 11/5/12 at 1:20 p.m., indicated the resident's record. Interview with the Director of Nursing on 11/5/12 at 1:20 p.m., indicated the resident's family should have received or been mailed a copy of the bed hold form in the resident's family should have received or been mailed a copy of the bed hold whare received or opinion point in the resident's cord. Social provision of the bed-hold form in the resident's careful to be affected by the same deficient practice will be identified and what corrective action(s) will be completed by SDD/designee. This audit will be completed by SDD/designee. This audit will be completed by SDD/designee. This audit will be completed by SDD/designee. The provision of the policy allowing the residents and/or family member or legal representative for residents and/or family member or legal representative or resident to return to the facility. Any errors or omissions noted during this audit will be completed by SDD/designee. The policy of the bed hold will be completed by SDD/designee. The policy of the bed hold will be completed by SDD/designee.			155115				11/05/	2012
1121 E LASALLE AVE				B. WIIV		ADDRESS CITY STATE ZID CODE		
CARDINAL NURSING AND REHABILITATION CENTER IXVID D SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MIST BE PRECEDED BY FULL PREFIX TAG (EACH DEPICIENCY MIST BE PRECEDED BY FULL PREFIX TAG) Ithey did not recall receiving a copy of the facility's bed hold policy and the policy allowing the resident to return to the facility bed hold policy and the policy allowing the resident through the policy allowing the resident was transferred to the hospital. The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident was sent to the Emergency room for evaluation and returned to the facility on 5/26/12. Documentation in the Resident progress note on 5/26/12 at 1:00 p.m., indicated the resident's daughter was present when the resident's daughter was present when the resident's daughter received a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy in the resident's chart. Interview with the Social Service Director for the Cottage Unit on 11/5/12 at 10:30 a.m., indicated that he could not find a bed hold form in the resident's record. Interview with the Director of Nursing on 11/5/12 at 11:20 p.m., indicated the resident's family should have received or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed hold or or been mailed a copy of the bed ho	NAME OF I	PROVIDER OR SUPPLIEF	₹					
ID PRIETY (PACH DEFICIENCY MIST BE PRECEDED BY PELL TAG REGULATORY OF LISE DEPITY IN TROMATION) They did not recall receiving a copy of the facility's bed hold policy and the policy allowing the resident to return to the facility the last time the resident was transferred to the hospital. The record for Resident #39 was reviewed on 11/1/12 at 9:38 a.m. The resident was sent to the Emergency room for evaluation and returned to the facility on 5/26/12. Documentation in the Resident progress note on 5/26/12 at 1:00 p.m., indicated the resident's daughter was present when the resident's daughter received a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy. Continued record review indicated there was not a copy of the bed hold policy in the resident's chart. Interview with the Social Service Director for the Cottage Unit on 11/5/12 at 10:30 a.m., indicated that he could not find a bed hold form in the resident's record. Interview with the Director of Nursing on 11/5/12 at 1:20 p.m., indicated the resident's family should have received or been mailed a copy of the bed hold policy for the bed hold policy allowing the resident are resident to a family member/legal representative hat specifies the duration of the bed hold policy under the State plan before a resident tansfers to a hospital or allows a resident to freapeutic leave. What corrective action(s) will be accomplished for those resident from the state plan before a resident tansfers to a hospital or the exident at safety for the serident to return to the facility and the duration of the bed hold policy in the resident to return to the duration of the bed hold policy in the resident to resident to accomplished for those resident to practice: Resident & family member/legal representative hat specifies the duration of the bed hold policy in the resident to return to the state plan before a resident to practice: Resident #39 — resident \$1 family member/legal representative hat specifies the duration of t	CARRIAN AND REMARK TATION CENTER		DELIABILITATION CENTED					
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or been mailed a copy of the bed hold omissions noted during this audit will be clarified and/or corrected							s or	
or been mailed a copy of the bed hold will be clarified and/or corrected			•					
		or been mailed	l a copy of the bed hold			_		
policy. She indicated the nurse who immediately. Resident transfers		policy. She ind	icated the nurse who			immediately. Resident transfe	ers	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
155115			B. WING		11/05/2012
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
1.1.1.1.1.01 1	IDDR OR GOLF BIBL	-		LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER	SOUTH	H BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		nt to the hospital was		and therapeutic leaves are	h
		e and she no longer		reviewed in the daily meeting the IDT. What measures will	-
	worked at the f	acility.		put into place or what system	
				changes will be made to	
	3.1-12(a)(25)(E	3)		ensure that the deficient	
				practice does not recur: A	
				mandatory nursing in-service	will
				be conducted on or before 12/5/12 by the DNS/designee.	
				This in-service will include rev	I
				of the facility Bed Hold Policy	
				the procedure for notification t	
				residents and/or family member	
				or legal representatives. Char Nurses will be responsible for	⁻ ge
				completing the Bed Hold Police	:v
				paperwork upon transfer or	'
				therapeutic leave, attaching th	е
				signed copy to the transfer	_
				paperwork and placing a copy	of
				the signed notification in the resident's clinical record. The	
				SSD/designee will be respons	I
				for ensuring all residents and/	
				family member or legal	
				representative have been give	en
				proper and timely notification regarding transfer and/or	
				therapeutic leave and have	
				received a copy of the facility's	3
				Bed Hold Policy and the policy	/
				allowing the resident to return	to
				the facility. The ED/DNS/designee will audit the	
				resident chart to ensure	
				necessary paperwork has bee	n
				provided to the resident/POA	
				upon transfer or discharge. He	I
				the corrective action(s) will k	be
				monitored to ensure the	
				deficient practice will not red	ur,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

155115 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	11/05/2012
NAME OF PROVIDER OR SUPPLIER 1121 E LASALLE AVE CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN 46617	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
i.e., what quality assurance program will be put into place: The ED/SSD/designee will be responsible for completing the CQI Audit Tool titled, "Discharge Planning" weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 12/5/12.	e ad

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETER			ETED	
		155115	B. WIN			11/05/	2012
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CARDINAL NURSING AND REHABILITATION CENTER		REHABILITATION CENTER			H BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
F0223 SS=D	483.13(b), 483.13 FREE FROM ABI	USE/INVOLUNTARY					
00 5	SECLUSION						
	The resident has	the right to be free from					
	-	nysical, and mental abuse,					
		ent, and involuntary					
	seclusion.						
	The facility must a	not use verbal, mental,					
		al abuse, corporal					
		voluntary seclusion.					
	Based on recor		F02	23	F223 – Free from		12/05/2012
		acility failed to ensure			Abuse/Involuntary Seclusion	It	
		vas free from abuse			is the practice of this provider		
					each resident has the right to I		
		ostantiated allegation ouse for 1 of 1 resident			free from verbal, sexual, physi	cal,	
					and mental abuse, corporal		
		ouse of the 1 resident			punishment, and involuntary		
		iteria for abuse.			seclusion. What corrective action(s) will be accomplished	- d	
	(Resident #62)				for those residents found to	ŧu	
					have been affected by the		
	Findings includ	e:			deficient practice: Resident #	‡62	
					- physician and family have be		
	On 10/30/12 at	: 9:43 a.m., during an			updated regarding this residen	ıt's	
	interview with F	Resident #62, she			current status. This resident		
		A got angry with her			experienced no negative		
		sked a question			psychosocial reaction or outco		
		clothes, and the CNA			related to this finding and is be treated with respect and dignit	-	
	threw her cloth	·			during ADL care. How other		
		old her daughter and			residents having the potentia		
		~			to be affected by the same		
	nei uaugiilei lu	old the Nursing staff.			deficient practice will be		
	D	mtomious on 44/4/40 -t			identified and what correctiv	е	
	_	nterview on 11/1/12 at			action(s) will be taken: All		
	,	resident indicated no			residents are at risk to be	ont	
		rude to her or mean			affected by this finding. Resid and family interviews were	CIII	
	since the incide	ent with the clothes in			conducted per CQI Abuse		
	which her daug	hter had already			Questionnaire devised by CMS	3	
	reported.				with no findings. The ED,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 155115 11/05/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1121 E LASALLE AVE CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN 46617 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DNS/designee will be responsible for conducting facility interviews The record for Resident #62 was with staff (including after hours reviewed on 11/1/12 at 3:04 p.m. The and on weekends) regarding resident's diagnoses included, but Abuse Prohibition, Reporting and were not limited to, uncontrolled Investigation. All staff in-services will be conducted on or before diabetes, history of stroke, obesity, 12/5/12. This in-service will depression, anxiety, and adjustment include review of the facility policy disorder. related to Abuse Prohibition, Reporting and Investigation and Review of the significant change review of the Elder Justice Act. What measures will be put into Minimum Data Set (MDS) place or what systemic assessment dated 3/14/12, indicated changes will be made to the resident was alert and oriented. ensure that the deficient She had no behaviors, and she practice does not recur: All staff needed some assistance with in-services will be conducted on or before 12/5/12. This in-service dressing. will include review of the facility policy related to Abuse Review of the incident form that was Prohibition, Reporting and dated 7/27/12, indicated Resident #62 Investigation and review of the reported to her daughter that CNA #3 Elder Justice Act. All staff will be re-educated regarding the various was assisting her with a change of types of abuse including clothing and mistreated her. Upon emotional abuse and the further investigation, the resident procedure for responding to and alleged to the Social Service Director timely reporting of any alleged or actual abuse situation. Any earlier in the day she was having allegation or statement regarding trouble deciding which article of resident abuse or mistreatment clothing to wear, and CNA #3 balled will be reported immediately to up three articles of clothing and threw the ED and/or DNS. The facility then into the resident's face and said will immediately initiate a full investigation as well as ensure "you decide." notification to the MD, family, ISDH and other agencies as The immediate action taken included outlined in the facility policy. The CNA #3 was suspended pending ED, DNS/designee will be results of the investigation. responsible for conducting this in-service. The ED,

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED
		155115	B. WIN	G		11/05/	2012
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN 46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	indicated there distress noted on an assessment of the provided care interviewed to a provided approvided incident occurre resident and he articles of cloth CNA acknowle frustrated with of the incident, indicated the reher of throwing person at the tin occurred. The the resident shat her at the tin CNA #3 further not report the anurse or nurse documented the manner. Further review up indicated the interviewed the The resident stather at the blouses in the provided approvided app	The Administrator also IA #3 who an unwitnessed ed between the erself involving three ing on 7/27/12. The dged she was the resident at the time The CNA also esident had accused her clothes on her me the incident CNA stated she told e did not throw clothes ne of the incident. Tacknowledged she did allegation to her charge supervisor nor e said incident in any of the five day follow e Administrator e resident on 7/30/12. ated the CNA threw in her face because			DNS/designee will be response for conducting facility interview with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting a Investigation. How the corrective action(s) will be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place. The ED, DNS/designee will be responsible for completion of CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 weethen monthly for 6 months to monitor for ongoing compliance of this corrective action. If threshold of 100% is not met, action plan will be developed. Findings will be submitted to to CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date 12/5/12.	vs s s and cur, ee: ehe eks ee an he H	
	interviewed the The resident st three blouses i	e resident on 7/30/12. ated the CNA threw					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155115	B. WIN			11/05/2	2012
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
CADDINI	AL NILIDRING AND	REHABILITATION CENTER			LASALLE AVE I BEND, IN 46617		
				<u> </u>	I BEND, IN 40017		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		3 stated to her that					
	_	make up her mind of					
		or her to go to the					
		it herself. The resident					
		the CNA would not					
	and did not hel	p her, she went to the					
		ected her clothing					
	herself.	-					
	Interview with t	the Administrator on					
		p.m., indicated he					
		d of the incident until					
	•	He further indicated he					
		rviewed the resident					
		and the resident					
		CNA threw the clothes					
		NA indicated that she					
		set with the resident, nt did accuse her of					
		othes at her, but she					
	_	or tell any staff member					
	•	further indicated the					
	_	inated due to not					
	reporting the in						
	allegation was						
	_						
	3.1-27(b)						

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/05/2012
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	A83.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and	F0225	F225 – Investigate/Report It is	s 12/05/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIHIDI	A. BUILDING 00		COMPLE	ETED
		155115	B. WING	110		11/05/2	2012
		1		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	3			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
						1	are.
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		EFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		ΓAG	· · · · · · · · · · · · · · · · · · ·		DATE
		acility failed to report			the practice of this provider the all alleged violations involving	al	
		f abuse immediately to			mistreatment, neglect, or abus	:e	
	the Administra	tor for 2 of 3 allegations			including injuries of unknown		
	of abuse revie	wed. (Residents #62,			source and misappropriation of	of	
	#86, and #131)			resident property are reported		
		-			immediately to the administrat		
	Findings include	de:			of the facility and thoroughly		
					investigated per facility policy.		
	1 On 10/20/1	2 at 9:43 a.m., during			What corrective action(s) will	1	
		•			be accomplished for those		
	an interview with Resident #62, she				residents found to have been	7	
		IA got angry with her			affected by the deficient practice: Resident #62, #86,		
	because she a	sked a question			#131 – physicians and families		
	regarding her	clothes, and the CNA			have been updated regarding		
	threw her cloth	ies at her. She			each resident's current status.		
	indicated she t	old her daughter and			These residents experienced i	no	
		old the Nursing staff.			negative psychosocial reaction	n or	
		3			outcome related to this finding		
	During further	interview on 11/1/12 at			Any allegation of abuse will be	•	
	. •	e resident indicated no			reported immediately to the	,	
					ED/DNS. How other resident	ts	
		rude to her or mean			having the potential to be affected by the same deficiel	nt	
		ent with the clothes in			practice will be identified and		
	1	ghter had already			what corrective action(s) will		
	reported.				be taken: All residents are at a		
					to be affected by this finding.		
	The record for	Resident #62 was			Resident and family interview		
	reviewed on 1	1/1/12 at 3:04 p.m. The			will be conducted per CQI Abu		
		noses included, but			Questionnaire devised by CMS	s	
		d to, uncontrolled			with no findings. The ED,		
		ry of stroke, obesity,			DNS/designee will be respons	ible	
		exiety, and adjustment			for conducting random facility interviews with staff (including		
	l .	ixiety, and adjustinent			after hours and on weekends)		
	disorder.				regarding Abuse Prohibition,		
					Reporting and Investigation.	Γhe	
		significant change			staff will be interviewed by		
	Minimum Data	Set (MDS)			ED/designee to ensure staff is		
	assessment da	ated 3/14/12, indicated			knowledgeable regarding		

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Event ID: 10ZI11

Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPL	COMPLETED	
		155115				11/05/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹						
CADDIN	AL NUIDCING AND	REHABILITATION CENTER			LASALLE AVE			
CARDIN	AL NURSING AND	REHABILITATION CENTER		30016	I BEND, IN 46617			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	the resident wa	as alert and oriented.			reporting of abuse. All staff			
	She had no be	haviors, and she			in-services will be conducted			
	needed some a	assistance with			or before 12/5/12. This in-ser			
	dressing.				will include review of the facili policy related to Abuse	ıy		
					Prohibition, Reporting and			
	Review of the i	ncident form that was			Investigation and review of the	Э		
	dated 7/27/12, indicated Resident #62				Elder Justice Act. What			
	•				measures will be put into pla	асе		
	reported to her daughter that CNA #3				or what systemic changes w	rill		
		ner with a change of			be made to ensure that the			
	_	istreated her. Upon			deficient practice does not			
	further investig	ation, the resident			recur: All staff in-services will			
	alleged to the	Social Service Director			conducted on or before 12/5/1			
	earlier in the da	ay she was having			This in-service will include rev	riew		
	trouble decidin	g which article of			of the facility policy related to Abuse Prohibition, Reporting	and		
		or, and CNA #3 balled			Investigation and review of the			
	_	es of clothing and threw			Elder Justice Act. All staff will			
	•	esident's face and said			re-educated regarding the var	ious		
		sident's lace and said			types of abuse including			
	"you decide."				emotional abuse and the			
					procedure for responding to a			
		action taken included			timely reporting of any alleged	l or		
	CNA #3 was si	uspended pending			actual abuse situation. Any	l!		
	results of the ir	nvestigation.			allegation or statement regard resident abuse or mistreatment	•		
					will be reported immediately to			
	Review of the f	five day follow up			the ED and/or DNS. The facil			
		was no psychosocial			will immediately initiate a full	,		
		for the resident based			investigation as well as ensure	е		
		nent by Social Service			notification to the MD, family,			
		•			ISDH and other agencies as			
		r residents who were			outlined in the facility policy.	The		
	l •	by CNA #3 were			ED, DNS/designee will be	_		
		determine if care was			responsible for conducting this	S		
	provided appro	priately and			in-service. The ED, DNS/designee will be respons	sihla		
	respectively. T	The Administrator also			for conducting facility interviev			
	interviewed CN	IA #3 who			with staff (including after hour			
	acknowledged	an unwitnessed			and on weekends) regarding	-		
	_	ed between the			Abuse Prohibition, Reporting	and		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155115	B. WIN			11/05/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			LASALLE AVE	
CADDINI	AL MILIDOING AND	REHABILITATION CENTER			BEND, IN 46617	
CARDINA	AL NURSING AND	REHABILITATION CENTER		300111	1 BEND, IN 40017	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	resident and he	erself involving three			Investigation. <i>How the</i>	
	articles of cloth	ing on 7/27/12. The			corrective action(s) will be	
	CNA acknowle				monitored to ensure the	
		the resident at the time			deficient practice will not rec	eur,
		The CNA also			i.e., what quality assurance	
					program will be put into place The ED, DNS/designee will be	
		esident had accused			responsible for completion of t	
	_	her clothes on her			CQI Audit tool titled, "Abuse	
	•	me the incident			Prohibition, Reporting and	
		CNA stated she told			Investigation" weekly for 4 week	eks
	the resident sh	e did not throw clothes			then monthly for 6 months to	
	at her at the tin	ne of the incident.			monitor for ongoing complianc	e
	CNA #3 further	acknowledged she did			of this corrective action. If	
		allegation to her charge			threshold of 100% is not met,	an
	nurse or nurse	•			action plan will be developed.	
		e said incident in any			Findings will be submitted to the CQI Committee for review and	
		e said incident in any			follow up. By what date the	
	manner.				systemic changes will be	
					completed: Compliance Date	e.
		of the five day follow			12/5/12.	
	up indicated th	e Administrator				
	interviewed the	e resident on 7/30/12.				
	The resident st	ated the CNA threw				
	three blouses i	n her face because				
		at her. She further				
		3 stated to her that				
		make up her mind of				
		•				
		or her to go to the				
	_	it herself. The resident				
		the CNA would not				
	and did not hel	p her, she went to the				
	closet and sele	ected her clothing				
	herself.					
		the Administrator on				
	11/1/12 at 4:45	p.m., indicated he				
	was not notified	d of the incident until				

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	155115		LDING	00	11/05/2012	
		100110	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	11/00/2012	
NAME OF P	PROVIDER OR SUPPLIER				LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG				TAG	BELLOWING	DATE	
		He further indicated he rviewed the resident					
	'	and the resident					
		NA threw the clothes					
		IA indicated that she					
		set with the resident,					
		nt did accuse her of					
		othes at her, but she					
	_	or tell any staff member					
	that night. He	further indicated the					
	CNA was term	inated due to not					
	reporting the in	cident timely.					
	_	on of Resident to					
		e dated 8/20/12,					
	_	lent #86 and #131, was					
	reviewed on 11	1/2/12 at 1:34 p.m.					
	The event was	witnessed by the					
	•	ry Food Manager on					
	8/19/12. She d	bserved Resident #86					
	standing in clos						
		, and without apparent					
	•	invitation, Resident					
	_	iss Resident #131					
	upon her lips.						
	The guarterly N	Minimum Data Set					
		ment dated 9/28/12,					
	, ,	dent #131 had a BIMS					
		for Mental Status)					
	,	nich indicated moderate					
	cognitive impai						
	The quarterly N	IDS assessment dated					

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP C	ODE
CARDINA	AL NURSING AND	REHABILITATION CENTER		E LASALLE AVE TH BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH	RECTION IOULD BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	DATE
	9/6/12, indicate	ed Resident #86 had a			
		12, which indicated			
	moderate cogn	itive impairment.			
	Posident #96 :	vas referred to psych			
		other female residents			
	•	ed to see if Resident			
	#86 tried to kis				
		he Administrator on			
		p.m., indicated the			
	•	ry Food Manager was			
	_	T(Interdisciplinary on 8/20/12. In that			
	,	nnounced to the team			
		sed Resident #86			
	kissing Reside	nt #131. She further			
	indicated at tha	at time, she did not			
	•	ent immediately to the			
		or anyone else. The			
		ndicated the event took			
	place on 8/19/1 him on 8/20/12	12 and was reported to			
	111111 011 0/20/12				
	3.1-28(c)				
	(-)				

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155115	B. WING			11/05/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	ETC POLICIES The facility must written policies at mistreatment, ne residents and mis property. Based on reco interview, the f the Abuse policitimeliness of re abuse immedia	acility failed to follow by related the eporting an allegation of	F022	26	F226 – Develop/Implement Abuse/Neglect, etc Policies I the practice of this provider to develop and implement writter policies and procedures that prohibit mistreatment, neglect and abuse of residents and	n	12/05/2012
		d. (Residents #86,)			misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to	ed	
	1. On 10/30/12 an interview wi indicated a CN because she a regarding her of threw her cloth indicated she ther daughter to During further 10:34 a.m., the staff has been since the incide which her daughter to which her daugreported.	2 at 9:43 a.m., during th Resident #62, she A got angry with her sked a question clothes, and the CNA			have been affected by the deficient practice: Resident #86, #131 – physician and fam have been updated regarding each resident's current status. These residents experienced negative psychosocial reaction outcome as a result of this finding. Any allegation of abus will be reported immediately to the ED/DNS. How other residents having the potentiato be affected by the same deficient practice will be identified and what correctivaction(s) will be taken: All residents are at risk to be affected by this finding. Resident family interviews were conducted per CQI Abuse Questionnaire devised by CM with no findings. The ED, DNS/designee will be response	nillies no no nor se o al	

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLI	ETED
		155115	B. WIN			11/05/2	2012
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CVDDIN	AL NITIDGING AND	REHABILITATION CENTER			I BEND, IN 46617		
CANDIN		REHABIEITATION CENTER		30011	- DEND, IN 40017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 1	1/1/12 at 3:04 p.m. The			for conducting facility interview		
	resident's diag	noses included, but			with staff (including after hours	8	
	were not limite	d to, uncontrolled			and on weekends) regarding	and l	
		ry of stroke, obesity,			Abuse Prohibition, Reporting a Investigation. All staff in-servi		
		ixiety, and adjustment			will be conducted on or before		
	disorder.	ixioty, and adjustinion			12/5/12. This in-service will		
	disorder.				include review of the facility po	olicy	
	Davison of the	-::C			related to Abuse Prohibition,		
		significant change			Reporting and Investigation ar	nd	
	Minimum Data	•			review of the Elder Justice Act	i.	
	assessment da	ated 3/14/12, indicated			What measures will be put in	ito	
	the resident wa	as alert and oriented.			place or what systemic		
	She had no be	haviors, and she			changes will be made to		
	needed some	assistance with			ensure that the deficient	1 - EE	
	dressing.				practice does not recur: All s in-services will be conducted or		
	arocomig.				or before 12/5/12. This in-services		
	Dovious of the	incident form that was			will include review of the facilit		
					policy related to Abuse	· y	
	-	indicated Resident #62			Prohibition, Reporting and		
	•	daughter that CNA #3			Investigation and review of the	,	
	was assisting h	ner with a change of			Elder Justice Act. All staff will	be	
	clothing and m	istreated her. Upon			re-educated regarding the vari	ious	
	further investig	ation, the resident			types of abuse including		
	alleged to the	Social Service Director			emotional abuse and the		
	_	ay she was having			procedure for responding to a		
		g which article of			timely reporting of any alleged	or	
		· ·			actual abuse situation. Any allegation or statement regard	ina	
		ar, and CNA #3 balled			resident abuse or mistreatmer		
		es of clothing and threw			will be reported immediately to		
		esident's face and said			the ED and/or DNS. The facili		
	"you decide."				will immediately initiate a full		
					investigation as well as ensure	•	
	The immediate	action taken included			notification to the MD, family,		
	CNA #3 was s	uspended pending			ISDH and other agencies as		
	results of the in				outlined in the facility policy.	he	
		coagaton.			ED, DNS/designee will be		
	Dovious of the	five day follow up			responsible for conducting this	6	
		five day follow up			in-service. The ED,	iblo	
	indicated there	was no psychosocial			DNS/designee will be respons	ible	

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Event ID: 10ZI11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155115	B. WIN			11/05/2	2012
	SUMMARY	R REHABILITATION CENTER STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		STREET A 1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN 46617 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on an assessing Director. Other provided care interviewed to provided approvided approvided approvided approvided approvided approvided approvided approvided incident occur resident and harticles of cloth CNA acknowled frustrated with of the incident indicated their her of throwing person at the occurred. The the resident shall at her at the till CNA #3 further not report the nurse or nurse documented the manner.	The Administrator also NA #3 who I an unwitnessed red between the erself involving three hing on 7/27/12. The edged she was the resident at the time The CNA also resident had accused g her clothes on her time the incident c CNA stated she told he did not throw clothes me of the incident. It acknowledged she did allegation to her charge e supervisor nor he said incident in any			for conducting facility interview with staff (including after hours and on weekends) regarding Abuse Prohibition, Reporting a Investigation. How the corrective action(s) will be monitored to ensure the deficient practice will not redice, what quality assurance program will be put into place. The ED, DNS/designee will be responsible for completion of the CQI Audit tool titled, "Abuse Prohibition, Reporting and Investigation" weekly for 4 week then monthly for 6 months to monitor for ongoing compliant of this corrective action. If threshold of 100% is not met, action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date 12/5/12.	and cur, ee: che eks ee an	
	up indicated the interviewed the The resident state three blouses she was angry alleged CNA #	ne Administrator e resident on 7/30/12. tated the CNA threw in her face because v at her. She further t3 stated to her that t make up her mind of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 10ZI11

Facility ID: 000048

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUI	LDING	00	COMPLETED 11/05/2012	
		199119	B. WIN	_		11/03/2012	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE	
TAG		or her to go to the		IAU		DATE	
		it herself. The resident					
		the CNA would not					
		p her, she went to the					
		ected her clothing					
	herself.	5					
	Interview with t	the Administrator on					
	11/1/12 at 4:45	p.m., indicated he					
		d of the incident until					
	1	He further indicated he					
	1 '	rviewed the resident					
	· ·	and the resident					
		CNA threw the clothes					
		NA indicated that she					
		set with the resident, nt did accuse her of					
		othes at her, but she					
		or tell any staff member					
	•	further indicated the					
	_	inated due to not					
	reporting the in						
		-					
		on of Resident to					
		e dated 8/20/12,					
	_	lent #86 and #131, was					
	reviewed on 11	1/2/12 at 1:34 p.m.					
	The event was	witnessed by the					
		ry Food Manager on					
	·	bserved Resident #86					
	standing in clos	se proximity to					
	Resident #131	and, without apparent					
	provocation or	invitation, Resident					
	#86 began to k	iss Resident #131					

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/05/2012		
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	· ·			AIE		
	Review of the current 9/12 Abuse					

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Event ID: 10ZI11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	COMPLETED 11/05/2012
	ROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 1121 E LASALLE AVE SOUTH BEND, IN 46617	DE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	Prohibition, Reporting, and Investigation Policy and Procedure, provided by the Administrator, indicated, "All abuse allegations/abuse must be reported to the Executive Director immediately and to the resident's representative within 24 hours of the report. Failure to report will result in disciplinary action, up to an including immediate termination." 3.1-28(a)		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIF			ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CADDINI	NI NILIDOINIO AND I	DELIADII ITATIONI CENTED			I BEND, IN 46617		
CARDINA	AL NURSING AND	REHABILITATION CENTER		30011	1 BEND, IN 400 I7		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241	483.15(a)						
SS=D	DIGNITY AND RE	ESPECT OF					
	INDIVIDUALITY						
		promote care for residents					
		n an environment that					
		ances each resident's					
	or her individuality	ct in full recognition of his v.					
		rvation, record review	F02	41	F241 – Dignity and Respect of	of	12/05/2012
	and interview. t	the facility failed to			Individuality It is the practice		
		sident's dignity was			this provider to promote care for	or	
		ed to the labeling of a			residents in a manner and in a	n	
		_			environment that maintains or		
		g a resident backwards			enhances each resident's dign	-	
		wn the hall and being exposed			and respect in full recognition	of	
		1 of 1 resident			his or her individuality. What		
	reviewed for dig	gnity. (Resident #118)			corrective action(s) will be accomplished for those		
					residents found to have beer	,	
	Findings includ	le:			affected by the deficient	'	
					practice: Resident #118 –		
	1. On 10/29/20	012 at 11:56 a.m.,			physician and family have bee	n	
		was observed in a geri			updated regarding this residen		
		in the dining room. At			current status. This resident's		
		#2 referred to the			wheelchair has been serviced	-	
	,				maintenance and is in working		
		eeder" and indicated			order. This resident experience		
		e in the back of the			no negative psychosocial reac		
	dining room wh	nere she was fed by			or outcome related to this findi	ng.	
	staff. There we	re other residents			Resident will be provided appropriate covering at all time	26	
	close to the CN	IA, and heard the CNA			and resident will be referred to		
	use the term "fe	•			her given name when being	S,	
	220 2.3 0				addressed. How other resider	nts	
	On 10/20/12 of	12:12 p.m., during the			having the potential to be		
					affected by the same deficier	nt	
		ne first floor dining			practice will be identified and		
		tenance Supervisor			what corrective action(s) will	1	
	walked into din	ing room holding four			be taken: Any resident who		
	folding chairs.	At that time, he stated			requires total assist with ADLs		
	to the staff "Do	you want these chairs			such as eating, dressing and		
		,			wheelchair mobility has the		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI III	LDING	00	COMPL	ETED
		155115	A. BUII B. WIN			11/05/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			I BEND, IN 46617		
			_		1 52(15), 114 10017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	for the feeders				potential to be affected by this finding. Customer Care Roun		
		ner residents in the			will be conducted daily by	us	
	_	aiting for lunch to be			Department Leaders on all un	its	
	served, and he	eard the Maintenance			including all shifts. Any reside		
	Supervisor use	the term "feeders."			dignity issues noted during the		
					Customer Care Rounds will be		
	On 10/31/12 at	t 3:36 p.m. the resident			corrected immediately. An all		
		in bed from the			staff in-service will be conduct on or before 12/5/12. This	iea	
		at time, the privacy			in-service will include review of	nf	
		lled in between the			the facility policy related to	, i	
	•	one and Resident			resident dignity and privacy		
	#118. Only the resident's upper body				issues including resident		
					"labeling" and pulling a reside	nt's	
		the hallway. The			wheelchair backwards. What		
		bserved lying sideways			measures will be put into pla		
		h of her legs bent			or what systemic changes w	'III	
		ody. The resident's top			be made to ensure that the deficient practice does not		
		n removed from her			recur: An all staff in-service w	rill	
	body and her p	oubic area was			be conducted on or before		
	exposed. The	resident was not			12/5/12. This in-service will		
	wearing pants	or an incontinent brief.			include review of the facility po	olicy	
					related to resident dignity issu		
	On 11/1/12 at 9	9:27 a.m., CNA #4 was			including resident "labeling" ar		
		ng the resident out of			pulling a resident's wheelchair		
	•	n and down the hall			backwards. This in-service wil also include review of the facil		
	_	ner geri recliner.			policy related to protecting a	ii.y	
		CNA #4 at that time,			resident's privacy during care	and	
		knew that she was not			when residents are in bed. The		
					DNS/designee will be respons		
		ull residents down the			for conducting this in-service.		
		but the chair wheels			addition, Customer Care Rour		
		v her to push the			by Department Leaders will be	.	
	resident forwar	d.			conducted daily on all units including all shifts. Any reside	•nt	
					dignity issues noted during the		
	The record for	Resident #118 was			Customer Care Rounds will be		
	reviewed on 11	1/1/12 at 9:30 a.m. The			corrected immediately. How		
	resident was a	dmitted to facility on			corrective action(s) will be		
		-					l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹		1	LASALLE AVE		
CADDINI	AL NILIDOING AND	REHABILITATION CENTER			BEND, IN 46617		
CARDINA	AL NURSING AND	REHABILITATION CENTER		300111	1 BEND, IN 40017		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3/5/12. The re	sident's diagnoses			monitored to ensure the		
	included, but w	vere not limited to, renal			deficient practice will not red	ur,	
	=	rition, dementia, failure			i.e., what quality assurance		
		ty, and chronic pain.			program will be put into plac		
	to tillive, alixie	ty, and omorno pain.			To ensure ongoing compliance	9	
	D	Minimum Data Oat			with this corrective action, the		
		Minimum Data Set			DNS/SSD/designee will be responsible for completion of t	hρ	
	, ,	ment dated 8/25/12,			CQI Audit tool titled,	110	
		esident was cognitively			"Dignity/Privacy" daily for 3		
	impaired, rarely	y understands and was			weeks, weekly for 6 months. I	f	
	rarely understo	ood. The resident was			threshold of 90% is not met, a	n	
	totally depende	ent on staff for			action plan will be developed.		
	dressing, eating, and personal				Findings will be submitted to the		
	hygiene.	5 , p			CQI Committee for review and		
	, 9.0				follow up. By what date the		
	Dovious of the	ourrent plan of care			systemic changes will be		
		current plan of care			completed: Compliance Date: 12/5/12.		
	•	9/12 and updated 8/12,			12/5/12.		
		esident has cognitive					
	loss. The Nurs	sing approaches were					
	to ensure priva	cy and dignity of the					
	resident.						
	Interview with t	the Third Floor Unit					
		1/1/12 at 11:23 a.m.,					
	_						
		esident thrashes a lot in					
		es very easily when					
	_	g to provide care. She					
	further indicate	ed the resident does lay					
	down after mea	als without her bottoms					
	and an incontir	nent brief on. The Unit					
	Manager also i	indicated at the time,					
	_	are the residents could					
		to as "feeder."					
	inor ne releired	10 43 155451.					
	0.4.000						
	3.1-3(t)						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00	COMPLETED 11/05/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE	
CARDINA		REHABILITATION CENTER		BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE

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Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155115		LDING		11/05/	2012
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE .	DATE
F0242	483.15(b)						
SS=D		NATION - RIGHT TO					
00 2	MAKE CHOICES						
		the right to choose					
		les, and health care					
	consistent with hi						
		d plans of care; interact					
		the community both inside					
		acility; and make choices					
	about aspects of	his or her life in the facility					
	that are significan	it to the resident.					
	Based on obse	rvation, record review	F02	42	F242 - Self-Determination -		12/05/2012
	and interview t	the facility failed to			Right to Make Choices It is th	е	
	ensure each resident's choice was				intent of this provider that each		
					resident has the right to choos		
	honored related	·			activities, schedules, and heal		
	preference on	going to bed at night			care consistent with his or her		
	and how many	times a week a			interests, assessments, and		
	shower was giv	en for 2 of 3 residents			plans of care; interact with		
	reviewed for ch				members of the community bo	th	
		met the criteria for			inside and outside the facility;	and	
					make choices about aspects of		
	choices. (Resi	dents #31 and #76)			his or life in the facility that are		
					significant to the resident. Wh	at	
	Findings includ	e:			corrective action(s) will be		
					accomplished for those		
	1. Interview wi	th Resident #31 on			residents found to have been	า	
		3 P.M., indicated he			affected by the deficient		
		•			practice: Resident #31 – an		
	•	bed around 8:00 p.m.			Activity Assessment and		
		cated he needed			"Preferences for Daily Custom Routines" Questionnaire was	ary	
	assistance to g	o to bed and his			completed for this resident. The	20	
	preference was	s to go to bed right			care plan and Nurse Aide	IC	
	•	nich was around 6:30			Assignment Sheet has been		
	p.m.				updated to reflect his bedtime		
	ν				preference. Resident #76 – a	n	
	The core of	Decident #04 ·····			Activity Assessment and		
		Resident #31 was			"Preferences for Daily Custom	arv	
	reviewed on 10)/31/12 at 1:59 p.m.			Routines" Questionnaire was	y	
	The resident's	diagnoses included,			completed for this resident. The	ne	
		nited to, anemia,			care plan and Nurse Aide	•	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155115		LDING		11/05/	
		100110	B. WIN			117007	2012
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	osteoarthritis,	chronic renal failure,			Assignment Sheet has been		
	stroke, and ora	al cancer.			updated to reflect her bathing		
					preference. How other	_1	
	Review of the	8/21/12 significant			residents having the potenti	aı	
		um Data Set (MDS)			to be affected by the same deficient practice will be		
	_	dicated the resident			identified and what corrective	70	
					action(s) will be taken: All	·	
		oriented, and had no			residents have the potential to	be.	
		ood problems. The			affected by this finding and wi		
	resident indica	ted it was very			identified through a facility aud		
	important to ch	oose his own bedtime.			This audit will be completed b		
	The resident was an extensive assist				the Activity Director/designee.		
	with one perso	n help for bed mobility,			Each resident or family		
	transfers, and toileting needs.				member/responsible party will		
	l'arisicis, aria	tolicting riccus.			have a "Preferences for Daily		
		1.7/04/40 1 5			Customary Routines"		
		current 7/31/12 plan of			Questionnaire completed as w	/ell	
	care indicated	the resident makes			as an updated Activity	. =1	
	poor choices a	s evidenced by history			Assessment. These complete Questionnaires and Assessment		
	of refusals of p	ersonal care. The			will be reviewed by the IDT.		
	Nursing approa	aches were to allow for			resident's care plan and Nurse		
		me or type of care			Aide Assignment Sheet will be		
		resident to express			updated as appropriate to refle		
	-	•			their personal preferences and		
	feelings and ve				choices regarding their daily		
	· ·	id allow resident to			routines and schedules.		
	participate in h	is plan of care as much			"Preferences for Daily Custom	nary	
	as possible.				Routines" are completed on		
					admission, annually, quarterly		
	Review of the	care card for the third			and with significant change.	-	
	floor indicated				changes to resident preference		
		vanting to go bed right			and choices regarding their da routines and schedules will be	-	
	•	as not listed on the			communicated and followed u		
					with in the daily meetings. Th	•	
		e only preference was			will ensure direct care staff is		
	•	nal on bed side table			aware of resident personal		
	uncovered and	I that he preferred a			preferences and choices for d	aily	
	shower before	breakfast.			activities such as bedtimes an	•	
					bathing choices. An all staff		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 11/05/2012	
		100110	B. WING		11/05/2012
CARDINA		REHABILITATION CENTER	1121 E SOUTH	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	3:47 p.m., indice the evening shows very familishe further indicated his choice was especially whe working, and thresident. Interview with I 3:44 p.m., indicated the indicated depended on was resident got to supper and if the preferences. During interview p.m., the Third indicated she was resident's preferences.	ho was working if the lay down right after		in-service will be conducted of before 12/5/12. The DNS/designee will be responsion for conducting this in-service. This in-service will include resofthe facility policy related to resident's rights and choices. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: An staff in-service will be conduction or before 12/5/12. The DNS/designee will be responsion for conducting this in-service. This in-service will include resident's rights and choices. Each resident or family member/responsible party will have a "Preferences for Daily Customary Routines" Questionnaire completed as a san updated Activity Assessment. These completed Questionnaires and Assessm will be reviewed by the IDT. I resident's care plan and Nurse Aide Assignment Sheet will be updated to reflect their person preferences and choices regarding their daily routines schedules. This will ensure of care staff is aware of resident personal preferences and choices regarding their daily routines schedules. This will ensure of care staff is aware of resident personal preferences and choices regarding their daily routines schedules. This will ensure of care staff is aware of resident personal preferences and choices. If the corrective action(s) will monitored to ensure the deficient practice will not refiece, what quality assurance	sible view nto all ted sible view I well ed ents Each e e e nal and direct i bices d flow be

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	OF CORRECTION IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/05/2012
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	2. Interview with Resident #76 on 10/30/12 at 9:39 a.m., indicated she preferred to have showers 4 times per week. She indicated she received showers two times per week. She also indicated she preferred to take a tub bath instead of a shower. The resident resided on the third floor of the facility. She was observed on 10/31/12 at 11:10 a.m., seated in a wheelchair in her room. Interview with the resident at that time, indicated she received showers on Mondays and on Wednesday. She stated she just had a shower. She indicated there was no bathtub in the facility, and she indicated she had asked in the past and was told there was no bath tub. She indicated if there was a bathtub she would be using it.		program will be put into place To ensure ongoing compliance with this corrective action, the DNS/designee will be response for completion of the CQI Audit tool titled, "Accommodation of Needs" daily for 3 weeks and weekly for 6 months. If thresh of 90% is not met, an action put will be developed. Findings were be submitted to the CQI Committee for review and folloup. By what date the system changes will be completed: Compliance Date: 12/5/12.	esible it sold lan ill

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155115	B. WI			11/05/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CVDDIVI	AL NILIDGINIC AND	REHABILITATION CENTER			LASALLE AVE BEND, IN 46617	
					DEIND, IIN 400 I <i>I</i>	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		Resident #76 was				
		/2/12 at 2:07 p.m. The				
	Annual Minimu	·				
		ited 2/13/12, indicated				
	the resident fel	·				
		ner to choose between				
	•	wer, or sponge bath.				
		-				
	The Quarterly I	MDS, completed on				
	9/16/12, indicat	ted the resident had a				
	Brief Interview	of Mental Status				
	(BIMS) score of 15, which indicated					
	the resident wa	s cognitively intact.				
		CNA #1 on 11/1/12 at				
	· ·	cated the shower room				
		or did not have a bath				
		ted she was not aware				
	,	s in the facility. She f a resident wanted a				
		ften than two times per ld make out a behavior				
	· ·	the staff would be				
		sident's request. She				
		dent #76 had never				
		at she wanted a				
		ften than 2 times per				
		indicated the resident				
		ted a tub bath be given				
	instead of a sh	•				
	Interview with t	he Social Service				
	Director on 11/	2/12 at 9:55 a.m.,				
	indicated she h	ad never been				
	informed of any	resident's request for				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMI	E SURVEY PLETED 5/2012
	PROVIDER OR SUPPLIER AL NURSING AND	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CO LASALLE AVE BEND, IN 46617	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	preferred a sho	licated if a resident ower more often than 2 c, the staff were to that request.				
	with the Director there was a fur first floor show used by reside tub baths. She aware the reside	3:50 a.m., interview or of Nursing indicated actional bathtub in the er room that could be nts who desired to take indicated she was not dent desired a tub bath re frequently than two				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/05/2012	
CARDINA	ROVIDER OR SUPPLIER	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0278 SS=A	The assessment resident's status. A registered nurs coordinate each a appropriate partic professionals. A registered nurs the assessment is the assessment rescuracy of that pure the assessment of the assessment of the assessment is supenalty of not mo assessment; or a and knowingly can certify a material resident assessment of each assessment of each assessment.	e must sign and certify that is completed. The completes a portion of must sign and certify the portion of the assessment. The cortion of the assessment. T			
	Based on obse and interview, ensure the resi assessment wa hospice and de resident review 1 of 3 residents	crvation, record review the facility failed to dent's comprehensive as accurate related to ental status for 1 of 1 red for hospice and for a reviewed for dental 4 residents who met	F0278	F278 – Assessment Accuracy/Coordination/Cert d It is the intent of this provide that each assessment must accurately reflect the resident status. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice: Resident	er ''s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.c	00	COMPL	ETED
		155115	A. BUIL			11/05/	2012
		1	B. WING	_			
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	the criteria for	dental. (Residents #80			#105 – MDS has been modifie	ed	
	and #105)				to accurately reflect her currer		
					status. This resident experier		
	Findings include:				no negative outcome related t		
	Findings include	ie:			this finding. Resident #80 – M		
					has been modified to accurate	•	
	1. The record for Resident #105 was				reflect her dental/oral status.		
	reviewed on 11/2/12 at 8:53 a.m. The				resident and family were offer		
		noses included, but			dental services and declined t		
	_				service. How other residents	5	
	were not limited to, high blood				having the potential to be		
	pressure, chronic anemia, cardiac				affected by the same deficie		
	arrhythmia, chronic renal failure,				practice will be identified an		
	dementia, expressive aphasia, stroke,				what corrective action(s) wil		
	and failure to t	-			be taken: Any resident requiri	-	
					a comprehensive assessment		
					has the potential to be affecte	-	
	-	sician Orders dated			this finding. A facility audit wil	l be	
	1/25/12, indica	ited the resident was			completed by the MDS		
	admitted to Ho	spice.			Coordinator/designee. All		
		•			resident care plans will be		
	Boylow of the	quarterly 10/4/12			reviewed and compared to the		
		quarterly 10/4/12			most recent comprehensive a	nd	
	Minimum Data	•			supplemental assessments		
	assessment in	dicated the section			during the next 90 days by the)	
	"Health Condit	ions" did not have the			IDT to ensure any resident	1	
	resident coded	l as having a condition			receiving Hospice Services ar		
		ease that may result in a			any resident that requires den		
		-			services are accurately asses		
		of less than 6 months.			and coded. This review will be		
	Hospice care v	vas indicated on the			completed by 12/5/2012. The	!	
	MDS.				Facility Activity Report and	wod	
					physician orders will be review daily by all disciplines to ensu		
	Review of the	Hospice Certification			information regarding resident		
		eatment signed by the			condition such as oral/dental	•	
		•			issues, Hospice orders and		
		0/12/12, indicated the			physician's orders are utilized	to	
	Physician had certified this patient				complete comprehensive and	Ü	
	was under his	care and to the best of			supplemental assessments as		
	his medical kn	owledge and given the			well as to update each resider		
		•			plan of care. All disciplines wi		
	uata avallable	the resident had the life			plan of care. All disciplines wi	111	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED
		155115	B. WING			11/05/2012
NAME OF P	DOMDED OF GUIDNI 150	1	'	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		1121 E	LASALLE AVE	
		REHABILITATION CENTER		SOUTH	BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	expectancy of	six months or less if			participate in the development	
	the illness runs	its normal course.			and ongoing revisions to the p	
	The Physician	authorized hospice			of care. What measures will	
	care as outline				put into place or what system changes will be made to	nic
					ensure that the deficient	
	Interview with t	he MDS Coordinator			practice does not recur: A	
					nursing in-service will be held	on
		1:00 a.m., indicated			or before 12/5/12. This in-serv	
		the resident was			will include review of the facilit	
	•	ce but further indicated			policy related to accuracy of	
	the coding on t	he MDS was			completion of comprehensive	and
	inaccurate rela	ted to the life			supplemental assessments	
	expectancy of	six months to live.			including any resident receivin	g
					Hospice Services and any	
					resident that requires dental	
					services. It will also review the	
					care plan process. The	or
					DNS/designee is responsible f conducting this in-service. The	ı
					Facility Activity Report and	5
					physician orders will be review	red
					daily by all disciplines to ensur	
					information regarding resident	ı
					condition such as oral/dental	
					issues, Hospice orders and	
					physician's orders are utilized	to
					complete comprehensive and	
					supplemental assessments as	
					well as to update each residen	
					plan of care. All disciplines will	
					participate in the development and ongoing revisions to the p	
					of care. How the corrective	iui i
					action(s) will be monitored to	,
					ensure the deficient practice	
					will not recur, i.e., what quali	ı
					assurance program will be p	_
					into place: To ensure ongoing	ı
					compliance with this corrective	
					action, the CQI Tool titled, "Ca	re
					Plan Updating" will be complet	ed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	00	COMPL	
		155115	B. WING			11/05/	2012
NAME OF P	ROVIDER OR SUPPLIER	·			ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER	S	JUIH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	\G	·	L.	DATE
					weekly for 4 weeks and month for 6 months. If threshold of 9	,	
					is not met, an action plan will be		
					developed. Findings will be		
					submitted to the CQI Committee	ee	
					for review and follow up. By		
					what date the systemic changes will be completed:		
					Compliance Date: 12/5/12.		
	2. Resident #8	0 was observed on			•		
	10/30/12 at 11:	13 a.m. She had					
	broken teeth no	oted on the bottom					
	portion of her n	nouth.					
		Resident #80 was					
)/31/12 at 12:22 p.m.					
	_	oses that included, but					
		d to, dementia and					
	adult failure to	thrive.					
	_	change Minimum Data					
	, ,	essment, dated					
	•	eviewed. It indicated					
		d no dental problems.					
		te the resident had					
		y cavity or broken					
	natural teeth.						
		are plan dated 3/2/12,					
		he resident had caries,					
	missing teeth /	ooor oral hygiene.					
		he MDS Coordinator					
		3:02 p.m., indicated					
		d some missing and					
	broken teeth. S	She indicated the					
			1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00	COMPLETED 11/05/2012	
	ROVIDER OR SUPPLIER AL NURSING AND I	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	significant char inaccurately co					
	3.1-31(d)					

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			ETED	
		155115	A. BUII B. WIN			11/05/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER						
CARDINA	AL NURSING AND	REHABILITATION CENTER		1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=E	CARE PLAN The services proving facility must be propersons in accord written plan of call		E03	92			12/05/2012
	and interview, the ensure Physicial plan of care were related to fall implace for 1 of 3 residents who accidents, nutriprovided as orderesidents of the the criteria forms kin conditions residents of the the criteria forms non-pressure remonitoring the giving Digoxin and not notifying elevated blood residents review medications. (#36, #68, and #456, #68, and #556, #68, #68, and #556, #68, #68, and #556, #68, #68, #68, #68, #68, #68, #68, #6	e 6 residents who met nutrition, not monitoring weekly for 1 of 3 e 3 residents who met skin conditions elated, and not apical pulse prior to (a heart medication) of the Physician of sugars for 2 of 10 wed for unnecessary Residents #15, #31, #137)	F02	82	F282 - Services by Qualified Persons/Per Care Plan It is the practice of this provider that services provided or arranged the facility must be provided by qualified persons in accordance with each resident's written plat of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #— physician has been notified or resident's pulse and blood pressure. Resident's apical pulse being obtained and recorded prior to giving Digoxin. This resident experienced no negate outcome related to this finding. Resident #31- has experienced no further weight loss and has been receiving the physician ordered supplement well as fortified mashed potatowith lunch and supper. The physician and the responsible party were made aware of this resident's current nutritional status. Resident #36 - has experienced no further falls. If all care plan and Nurse Aide Assignment Sheet has been reviewed and updated to reflect his current status. Resident#6 physician and family has been	by y ean ed ed en ed ed ed en ed	12/05/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, D	LDING	00	COMPL	ETED
		155115		LDING		11/05/	2012
			B. WIN		ADDRESS OVEN STATE OF CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					updated and informed of this		
	On 11/1/12 at 9	9:27 a.m., and 2:59			resident's current skin condition	n	
					and past and recent accuched	k	
	p.m., the resident was seated in a				results and any accucheck res	sults	
		ttage dining room. The			outside the physician ordered		
		gain observed picking			parameters. The care plan wa		
	at the scab on	his left hand.			updated to reflect this resident	r's	
					current skin condition. This	H	
	The record for	Resident #68 was			resident experienced no negation	uve	
		0/31/12 at 2:07 p.m.			outcome as a result of this finding. Resident #137- has		
		diagnoses included,			experienced no weight loss ar	nd.	
		•			lab values are within normal	iu	
	but were not limited to, diabetes and				limits. He has been receiving	the	
	behavior distur	bance.			physician ordered cottage che		
					at all meals. The physician ar		
	A Physician's o	order dated 10/8/12,			the responsible party were ma		
	indicated the re	esident was to have			aware of this resident's curren		
	bactroban ointi	ment applied to the top			nutritional status. How other		
		and to the top of his			residents having the potentia	al	
		a day for 10 days then			to be affected by the same		
		·			deficient practice will be		
		ue to picking at the sore			identified and what correctiv	е	
	on the top of hi	is ieπ nand.			action(s) will be taken: All		
					residents have the potential to		
	The Weekly Sk	kin Summaries dated			affected by this finding. A faci	lity	
	10/8, 10/16 and	d 10/30/12, indicated			audit will be conducted by the Nurse Management Team. The	nie	
	the resident ha	id no changes in			audit will include review of the		
	condition since	the last weekly			following: fall care plan review		
		form indicated the			nutritional supplement orders,	,	
	resident had "r				skin condition review, medicat	ion	
	l lesident nad 1	io skiii aicas.			administration review and bloc	od	
	The state of	4-1-4-0/00/10			glucose monitoring review. The	ne	
	·	re dated 9/20/12,			most current Physician Rewrit		
		esident was at risk for			Sheet will be compared by the	;	
	skin breakdow	n due to incontinence,			Nurse Management		
	decreased mol	bility due to the			Team/designee to MARs, care		
		iabetes, heart disease,			plans and Nurse Aide Assignn		
	_	ry problems, and picks			Sheets to ensure all physician		
		• •			orders are being followed as		
	ı auskiii. Tile ili	terventions indicated	1		written and that all related care	=	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLE	TED
		155115	B. WIN			11/05/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1			
CADDIN	AL NUIDCINIC AND	DELIABILITATION CENTED			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		30016	I BEND, IN 46617		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the resident wa	as to be			plans are accurately reflecting		
	encouraged/re	directed to not pick at			each resident's current status.		
	his skin and assess/document skin				Any discrepancies noted durin	٠ .	
	condition weekly and as needed and				this review will be clarified and corrected at the time noted. A		
		nysician of abnormal			mandatory nursing in-service		
	findings.	Tysician of abnormal			be conducted on or before	vv111	
	illiuligs.				12/5/12 by the DNS/designee.		
	Indiana i iii	LDN 40 - 44/5/40			This in-service will include rev		
		LPN #2 on 11/5/12 at			of the facility policy related to		
		dicated the issue with			following established physicial		
	the resident's hand was reoccurring				orders and Care Plan Review		
	and should have been documented				Maintenance. What measure	_	
	on the weekly skin assessment sheet.				will be put into place or what		
	,				systemic changes will be ma	ide	
	A Physician's o	order dated 5/30/12 and			to ensure that the deficient		
		nt on the 10/12			practice does not recur: A		
					mandatory nursing in-service	WIII	
	1	der Summary (POS),			be conducted on or before 12/5/12 by the DNS/designee.		
		esident was to receive			This in-service will include rev		
	•	test to monitor the			of the facility policy related to		
	blood sugar) tv	vice a day at 7:00 a.m.			following established physicial	n's	
	and 4:00 p.m.	The Physician was to			orders and Care Plan Review		
	be called if the	blood sugar was			Maintenance. All nursing staff	fwill	
	greater than 20	•			be re-educated on the process		
	g. como mom =				reviewing, updating and follow		
	Paview of the	August, September,			all resident care plans specific	ally	
					related to falls, nutritional		
		012 Blood glucose			supplements, follow up to		
	_	eets, indicated the			non-pressure skin conditions, obtaining and recording vital		
		d sugar was above 200			signs prior to medication		
	on the followin	g dates and times;			administration and adherence	to	
	however, the re	esident's physician was			physician call parameters rela		
	not notified as	ordered:			to blood glucose monitoring ar		
					accucheck results. The most		
	8/6 4·00 n m	blood sugar 256, 8/25			current Physician Rewrite She		
	•	od sugar 216, and			will be compared by the Nurse		
	•	•			Management Team/designee		
	0/29/12 4:00 P	.m., blood sugar 214.			MARs, care plans and Nurse		
					Assignment Sheets to ensure	all	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155115	B. WIN			11/05/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	₹		1121 E	LASALLE AVE	
CARDIN	AL NURSING AND	REHABILITATION CENTER			I BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE
	•	blood sugar 244, 9/9			physician orders are being followed as written and that all	
		od sugar 271, 9/12 4:00			related care plans are accurat	
	p.m., blood sugar 238, and 9/23/12 4:00 p.m., blood sugar 207.				reflecting each resident's curre	-
					status. Any discrepancies not	
					during this review will be clarif	
	10/22 4:00 p.m	n., blood sugar 238 and			and/or corrected at the time	
	10/23/12 4:00 p.m., blood sugar 208.				noted. How the corrective	
					action(s) will be monitored to	
	The current ola	an of care indicated the			ensure the deficient practice	
	resident was at risk for adverse effects of hyperglycemia or hypoglycemia (high or low blood				will not recur, i.e., what quali	_
					assurance program will be point place: Ongoing compliant	
					with this corrective action will I	
		. •			monitored though the facility C	
	1	to use of glucose			program. The DNS/designee	
	lowering medic				be responsible for completion	
		abetes mellitus. The			the CQI Audit tool titled, "Care	
		ndicated to document			Plan Updating" weekly for 4	14
		ngs and notify the			weeks, monthly for 6 months. threshold of 90% is not met, a	
	physician.				action plan will be developed.	
					Findings will be submitted to the	ne
	Interview with	the Assistant Director			CQI Committee for review and	
	of Nursing on	11/2/12 at 9:40 a.m.,			follow up. By what date the	
	indicated the p	hysician should have			systemic changes will be	
	been notified if	the resident's blood			completed: Compliance date	=
	sugar was grea	ater than 200 as			12/5/12.	
	ordered.					
	3,45,54.					
	2 The record	for Resident #15 was				
		0/31/12 at 9:33 a.m.				
		diagnoses included,				
	but were not lin	•				
	i tibrillation (an i	rregular heartbeat).				
	The plan of ca	re dated 6/6/12 and				
	reviewed 9/12,	indicated the resident				
	was at risk for	adverse drug reactions				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE S COMPL 11/05/	ETED	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	112	21 E I	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN 46617		
				ОТП	DEND, IN 40017		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREF	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	medication) fo fibrillation. On indicated the r	iving digoxin (a heart r the diagnosis of atrial e of the interventions esident's apical pulse cked prior to giving the					
	(MAR), indicat documented p medication on 10/3, 10/7, 10/ 10/13, 10/14, 2	October 2012 ministration Record ed there was no pulse rior to giving the the following dates: 8, 10/9, 10/11, 10/12, 10/17, 10/18, 10/19, 10/24, 10/26-10/29, and					
	no pulse was o 9/11, 9/13, 9/1	er 2012 MAR, indicated documented on 9/3, 4, 9/24 and 9/25/12.					
	indicated no p	August 2012 MAR, ulse was documented I0, 8/22, and 8/23/12.					
	of Nursing on indicated the reshould have be	the Assistant Director 11/2/12 at 9:45 a.m., esident's apical pulse een checked and rior to giving the					
	Resident #31 v	2 at 12:25 p.m., was observed in the ating his lunch meal. At					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155115	B. WIN	G		11/05/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CADDIN	AL NUIDCING AND				LASALLE AVE		
		REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		esident was served a		0			5.112
		he resident had a					
	•	olate milk and cup of					
	an orange drink. There was no can of Ensure or another cup with the Ensure in it by his lunch tray. On 11/1/12 at 12:50 p.m., the						
		bserved eating his					
		ning room. The					
		erved a pureed lunch					
	that consisted of broccoli, noodle						
		readstick, and a resident did not receive					
		ed potatoes. The					
		erved a carton of					
		and glass of fruit					
		sident did not receive					
	any Ensure su						
	,	F F					
	Interview with	the resident at that					
	time, indicated	sometimes he gets the					
	ensure sometii	mes he does not.					
		Dietary Aid #1 on					
		58 p.m., indicated she					
		the resident was to					
		tified mashed potatoes.					
		licated everyone who					
	•	oods also gets the					
	regular entree	as well.					
	The record for	Resident #31 was					
		0/31/12 at 1:59 p.m.					
		diagnoses included,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND FLAN	OF CORRECTION	155115	A. BUII B. WIN	LDING	00	11/05/	
NAME OF I	DROWINED OR CLIRRI IEI		B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	l	
	PROVIDER OR SUPPLIEF				LASALLE AVE		
		REHABILITATION CENTER			BEND, IN 46617		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		mited to, anemia, chronic renal failure, al cancer.					
	current recap original order of	sician Orders on the dated 10/12, with the date of 5/22/12, are Plus eight ounce 1					
	dated 5/18/12, was to receive	ary Progress Notes indicated the resident fortified mashed unch and supper.					
	potential for all related to being altered and the resident receivement nutritional approaches we equipment, prophysician order	esident had the teration in nutrition g on a mechanically erapeutic diet. The red supplements to help al needs. The Nursing ere to provide adaptive evide supplements per ers, monitor weights and ant weight changes to					
	on 11/1/12 at 2 Ensure supple units by the die placed on the i	the Director of Nursing 2:00 p.m., indicated the ment was sent to the etary department and resident's trays. the Consultant Dietary					

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Event ID: 10ZI11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155115	B. WIN			11/05/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CARDINI	AL NITRSING AND	REHABILITATION CENTER			LASALLE AVE I BEND, IN 46617		
				<u> </u>	I DEND, IN 40017	1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Food Manager	on 11/1/12 at 2:00					
	p.m., indicated						
	supplement wa	as to be placed on the					
	food trays duri	ng the meal times from					
	dietary. She fu	urther indicated she					
	was unaware t	he resident was					
		e receiving fortified					
	mashed potato	es all along.					
		0 / / 0 0 7					
		2 at 10:37 a.m., and					
	· ·	esident #36 was					
		g in a broda wheelchair					
		he resident was					
		a hoyer lift pad n. At that time, there					
		the resident's room.					
		as in the room with his					
	roommate.	as in the room with his					
	Toommuto.						
	On 10/31/12 a	t 1:37 p.m., CNA #5					
		Floor Unit Manager					
		place the resident in					
		hoyer lift. The resident					
	was lifted by th	ne hoyer and placed					
	into the bed. A	t that time, there was					
	no dycem (a p	iece of adhesive					
	•	vent the resident from					
) noted in the resident's					
		indicated at the time					
		ow the resident was to					
		in his wheelchair. She					
		ed she had laid him					
		akfast to change his					
		placed him back into					
	the wheelchair						

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			Ì	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 11/05/	ETED
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN 46617		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	reviewed on 1 The resident's but were not li blood pressure osteoarthritis, depressive dis of his arm. Review of Phy 10/26/12, indic wheelchair for comfort. Anot dated 10/18/13 dycem to the verification of the dated 2/25/11 10/25/12 indic risk for falls duability, stroke, wheelchair and down, slides of history of falls crawling out of approaches were sident when screen for a we pajama pants, extra long high lowest position unattended in	chronic pain syndrome, sorder, and amputation vsician Orders dated cated to utilize a broda positioning and her Physician Order 2, indicated to add					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155115	B. WIN	١G		11/05/	2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TOTAL OF T	KO VIDEK OK SOI I EIEI				LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the Third Floor Unit					
		0/31/12 at 2:00 p.m.,					
		lycem had not been					
	l •	chair because it was a					
	new chair for the	ne resident.					
	Intorvious with	Third Floor Unit					
		1/2/12 at 3:00 p.m.,					
	l –	esident should not be					
		s room due to his high					
		nd he should have a					
	· ·	heelchair all the time.					
	*	37 was observed on					
		29 a.m., in his bed. The					
		ist received his					
	1	He was served 8					
	1	milk (not lactose free),					
		cereal, eggs, sausage					
		slices. He was not					
	served cottage						
	On 10/31/12 at	t 12:40 p.m., the					
	resident had hi	is lunch tray, he did not					
	receive cottage	•					
	On 11/1/12 at	12:45 p.m., the					
	resident was e	ating lunch, he was					
	served broccol	li, ambrosia, garlic					
	bread and chic	ken with spaghetti					
	noodles. The r	esident did not receive					
	cottage cheese	Э.					
		as in the Main Dining					
		/12 at 8:48 a.m. He had					
	his breakfast tr	ay. He was served					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPI	LETED
		155115	B. WIN			11/05	/2012
		I .			ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIE	R			LASALLE AVE		
		REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DELCE:NO.1)		DATE
		ilk, sausage and					
	·	s of hot cereal and 2					
		here was an eight					
		of 2% milk on his tray.					
		cottage cheese served					
	to the resident	•					
	, ,	hologist was seated					
	next to the res	ident.					
	Intonvious on 1	1/2/12 at 10:35 a.m.,					
		•					
	with the Speed	•					
		dicated the resident					
		d cottage cheese with					
		on 11/2/12. She also					
		ad a glass of milk and a					
	carton of milk.						
	The record for	Resident #137 was					
	reviewed on 10	0/31/12 at 9:06 a.m.					
		ad diagnoses that					
		vere not limited to, end					
	stage renal dis	·					
		The resident received					
	••	imes per week.					
		anno por wook.					
	There was a c	are plan dated 10/30/12					
	that indicated:						
	Potential for al	teration in nutrition					
	related to resid	dent requires					
		et related to end stage					
		hypertension and					
	receives dialys	• •					
	1	terventions included:					
		l at breakfast, cottage					
		imes a day and Nepro					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155115	B. WIN			11/05/	2012
NAME OF P	ROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE		
CADDINI	AL NUIDOING AND	DELIABILITATION CENTED			LASALLE AVE		
	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEI (CIENCI)		DATE
	-monitor weigh-diet per physic						
	-diet per priysit	ciair s order					
	Th a	haiaia a Oudan data d					
		hysician Order dated					
	-	indicated to add					
	_	e 1/4 cup TID (three add double supercereal					
	• •	id lactose free milk (soy					
	or rice milk OK	` •					
	problem.	y for fluthional					
	рговісті.						
	Interview with t	the Nurse Consultant					
		2:35 p.m., indicated the					
		d not have been served					
		ndicated he was to					
	receive lactose						
	Interview with	the Director of Nursing					
		3:18 a.m., indicated					
		e should have been					
	_	sident as ordered by					
	the physician.	•					
	. ,						
	3.1-35(g)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/05/2012	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE H BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	HIGHEST WELL Each resident must provide the services to attain practicable physipsychosocial we the comprehensicare. Based on obse and interview, ensure non prowere assessed 3 residents revisidents who conditions non (Residents #39). Findings included 1. On 10/30/1 Resident #68 as a scabbed are his left hand. On 11/1/12 at p.m., the resident was a at the scab on The record for reviewed on 10 The resident's	ust receive and the facility necessary care and or maintain the highest ical, mental, and ill-being, in accordance with ve assessment and plan of ervation, record review the facility failed to essure skin conditions d and monitored for 3 of viewed of the 3 met the criteria for skin pressure related. Po, #68, and #98) de: 2 at 2:08 p.m., was observed picking at a above his knuckle on 9:27 a.m., and 2:59 ent was seated in a ottage dining room. The again observed picking his left hand. Resident #68 was 0/31/12 at 2:07 p.m. diagnoses included, mited to, diabetes and	F0309	F309 – Provide Care Service for Highest Well Being It is the practice of this facility to provide the necessary care and service to attain or maintain the higher practicable physical, mental, a psychosocial well-being, in accordance with the comprehensive assessment a plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #68, #98 - physician and family have been updated and inform of each resident's current skind condition. Skind conditions have been assessed and monitored Care plans and Nurse Aide Assignment Sheets have been updated to reflect each resident current status. These resident experienced not negative outcomes related to this finding. How other residents having potential to be affected by the same deficient practice will in identified and what corrective action(s) will be taken: All residents are at risk to be affected by this finding. Weeken affected by this finding. Weeken affected by this finding. Weeken affected by this finding.	ne de

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nnia	00	COMPL	ETED
		155115	1	LDING		11/05/	2012
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
0.4.00.11.1		DELLA DILITATIONI GENTED			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					Skin Assessments will be		
	A Physician's o	order dated 10/8/12,			completed on all residents as		
		esident was to have			as skin inspections during rou		
		ment applied to the top			bathing and shower care. Any		
					new skin issues noted such as		
		and to the top of his			bruising, discolorations or skir		
		a day for 10 days then			tears will be promptly investigated and followed up with to determ		
		ue to picking at the sore			cause. In addition, A Non	ııı I C	
	on the top of hi	is left hand.			Pressure Skin Evaluation Rep	ort	
					will be completed to ensure al		
	The Weekly Sk	kin Summaries dated			skin areas are assessed and		
	1	d 10/30/12, indicated			monitored closely until resolve	ed.	
	· ·	id no changes in			Shower Sheets and Weekly		
		•			Summaries will be reviewed d	aily	
		the last weekly			during clinical meetings by the	;	
	1	form indicated the			Nurse Management		
	resident had "r	no skin areas."			Team/designee to ensure all		
					current skin areas are noted o	n	
	The Quarterly	Minimum Data Set			shower sheets and Weekly		
	assessment da	ated 9/4/12, indicated			Summaries and any new area are followed up with according		
		id an open lesion other			policy. A nursing in-service w	-	
	than ulcers, ras	-			be held on or before 12/5/12.		
	l triair diccis, ra	siles and cuts.			The DNS/designee is respons	ible	
	The plan of ear	4-4-4 0/20/40			for conducting this in-service.		
		re dated 9/20/12,			This in-service will include rev	iew	
		esident was at risk for			of the Skin Management Police		
	skin breakdow	n due to incontinence,			What measures will be put in	nto	
	decreased mol	bility due to the			place or what systemic		
	diagnoses of d	iabetes, heart disease,			changes will be made to		
	_	ry problems, and picks			ensure that the deficient		
		terventions indicated			practice does not recur: A		
	the resident wa				nursing in-service will be held or before 12/5/12. The	UN	
					DNS/designee is responsible	for	
	_	directed to not pick at			conducting this in-service. Th		
		sess/document skin			in-service will include review of		
		dy and as needed.			the Skin Management Policy.		
	Notify the Phys	sician of abnormal			Weekly Skin Assessments wil	l be	
	findings.				completed on all residents as		
					as skin inspections during rou		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CADDIN	AL MILIDOING AND	REHABILITATION CENTER			BEND, IN 46617		
CARDIN	AL NURSING AND	REHABILITATION CENTER		30011	1 BEND, IN 40017		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Interview with	LPN #2 on 11/5/12 at			bathing and shower care.		
	10:45 a.m., ind	licated the issue with			Shower Sheets and Weekly		
	the resident's hand was reoccurring				Summaries will be reviewed d	aily	
		ve been documented			by the Nurse Management		
		skin assessment sheet.			Team/designee during clinical meetings to ensure all current		
	On the weekly	skiii assessiiieiit siieet.			skin areas are noted on show		
	0 0 40/00/4	0 -1 10:00			sheets and Weekly Summarie		
		2 at 12:36 p.m.,			and any new areas are followed		
		was observed with a			up with according to policy. A		
	skin tear to his	right elbow.			new areas of impaired skin		
					including bruising, discoloratio		
	On 10/31/12 at	t 8:11 a.m., 9:18 a.m.,			and skin tears will be promptly	,	
	10:40 a.m., and 2:30 p.m., the				investigated by the Nurse		
	resident was o	•			Management Team/designee	and	
		area to his right elbow.			followed up with to determine		
		area to his right elbow.			cause. How the corrective		
		D : 1 / //00			action(s) will be monitored to ensure the deficient practice		
		Resident #39 was			will not recur, i.e., what quali		
		1/1/12 at 9:38 a.m. The			assurance program will be p	-	
	resident's diag	noses included, but			into place: The DNS/designed		
	were not limite	d to, chronic anemia			will be responsible for complet		
	and dementia.	An entry in the			of the CQI Audit Tool titled,		
	Resident progr	ress note dated			"Bruises" daily for 3 weeks,		
		19 a.m., indicated the			weekly for 6 months to monito	r	
		ound by the CNA on the			for ongoing compliance. If		
		ees in his room. A			threshold of 90% is not met, a	n	
					action plan will be developed.		
		tear to the right elbow			Findings will be submitted to the CQI Committee for review and		
		small amount bloody			follow up. By what date the		
		skin tear to right index			systemic changes will be		
	finger, and a si	mall bruise and bump			completed: Compliance Date	:	
	to the right kne	ee was purple in color.			12/5/12.		
	A Physician's o	order dated 10/29/12,					
		esident was to have					
		ied to the right elbow					
		r three times a day for					
	7 days then dis	scontinue.					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COM	TE SURVEY PLETED 05/2012	
	PROVIDER OR SUPPLIER		B. WING THOS/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	The Weekly Sk 10/30/12, indict the right elbow were not identiful. Interview with 10:58 a.m., indice were not docur assessment sh 3. Resident #9 10/30/12 at 9:5 bruise that was the back of her On 10/31/12 at on the back of inches by 1 incompurple in color. On 11/1/12 at was 2 inches in The record for reviewed on 12 resident had disturbance and 2012 Physician the resident had milligrams daily	sin Assessment dated ated the skin tears to and right index finger fied. LPN #2 on 11/5/12 at licated the skin tears mented on the skin teet dated 10/30/12. 8 was observed on 88 a.m. She had a sthe size of a dime on left hand. 11:13 a.m., the bruise her left hand was 2 th in size and was light 10:15 a.m., the bruise her size. Resident #98 was 1/1/12 at 8:45 a.m. The agnoses that included, mited to, advanced sease with behavioral danxiety. The October of Order Sheet indicated ad orders for Aspirin 81					

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155115	B. WIN	G		11/05/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CADDIN	AL NUIDCING AND				LASALLE AVE		
CARDIN		REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710	Nursing Summ	<u> </u>	+	1110			DATE
		dated 10/25/12,					
		esident had no bruise.					
		evidence of a "Weekly					
	Nursing Summary and Skin Assessment" in the record after						
	10/25/12.						
		sing progress notes					
		2 through 11/1/12,					
		was no evidence the					
		back of the resident's					
	and monitored	dentified, assessed					
	and monitored	•					
	The nursing ca	are card, updated					
	_	ated the resident was					
	· ·	eding and bruising."					
		3 3					
	Review of the	form titled "Shower					
	Report" dated	11/1/12, that was					
	signed by the	CNA and the Licensed					
	Nurse, did not	indicate the resident					
	had a bruise o	n her left hand.					
		0.04					
		9:31 a.m., the bruise					
		the resident's left hand n color and was 2					
		Interview with LPN #1					
		dicated she first noted					
	1	morning, on 11/2/12.					
		the resident had a					
		v and thought that					
		ause of the bruise. She					
		esident was scheduled					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ekly Nursing Summary					
		ssment" completed on					
		indicated there was no					
		kin assessment was					
	•	that day. She indicated					
		ly Nursing Summary					
		ssment" completed for					
	the resident wa	as dated 10/25/12.					
		d, "Skin Management					
	1	was revised on 6/2012					
		by the Nurse Consultant					
	on 11/2/12. Sh	e indicated the policy					
	was current. Ti	he policy indicated,					
	"Residents will	have a skin					
	assessment co	ompleted no less than					
	weekly by the I	licensed nurse in an					
	effort to assess	s overall skin condition,					
	skin integrity a	nd skin impairment					
	Weekly skin a	assessments will be					
	completed on a	all residents with or					
	without alterati	ons in skin integrity and					
	documented or	n the weekly skin					
	assessment fo	rm and/or nursing					
	notes Any	skin alterations noted					
	I	givers during daily care					
	and/or shower	days must be reported					
	to the licensed	nurse for further					
	assessment, to	o include bruises, open					
		s, skin tears, blisters					
	and rashes."	·					
	Interview with	the Nurse Consultant					
		9:45 a.m., indicated					
		evidence that the bruise					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 11/0	e survey pleted 5/2012
	PROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CO LASALLE AVE I BEND, IN 46617	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	on the resident's hand had been identified, assessed and monitored. She indicated the shower sheet did not identify the resident's bruise and the "Weekly Nursing Summary and Skin Assessment" was not completed timely. 3.1-37(a)				

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Event ID: 10ZI11

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
CARDINA	AL NURSING AND	REHABILITATION CENTER		E LASALLE AVE TH BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0323 SS=D	483.25(h) FREE OF ACCID HAZARDS/SUPE The facility must e environment rema hazards as is pos receives adequate assistance devices Based on obse and interview, t ensure a reside from accidents devices for 1 of for accidents of met the criteria (Resident #36) Findings includ On 10/31/12 at a.m., Resident sitting in a brod room. The resi with a hoyer lift At that time, the resident's room the room with h On 10/31/12 at and the Third F going to place t using the hoyel lifted by the hoy bed. At that time	ENT REVISION/DEVICES ensure that the resident ains as free of accident esible; and each resident e supervision and es to prevent accidents. rvation, record review the facility failed to ent was safe and free related to positioning f 3 residents reviewed f the 6 residents who for accidents. e: 10:37 a.m., and 11:25 #36 was observed la wheelchair in his ident was observed pad underneath him. ere was no staff in the n. The resident was in	F0323	F323 – Free of Accident Hazards/Supervision It is the practice of this provider to enthat the resident environment remains as free of accident hazards as is possible; and e resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) whe accomplished for those residents found to have been affected by the deficient practice: Resident #36 – has experienced no further falls. fall care plan and Nurse Aide Assignment Sheet has been reviewed and updated to refle his current status. How other residents having the potent to be affected by the same deficient practice will be identified and what correctinaction(s) will be taken: Any resident identified as being affor falls has the potential to be affected by this finding. A fact audit will be completed by the Nurse Management Team to review all resident fall care plant the prevention interventions each resident's fall care plant.	12/05/2012 sure ach His ect r ial ve crisk e cility e ans. on
	prevent the res	ident from sliding		be compared to the Nurse Aid	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	, DDIG	00	COMPL	ETED
		155115		LDING		11/05/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIEI	₹					
CADDIN	AL NUIDOING AND	REHABILITATION CENTER			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		30016	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	forward) noted	in the resident's chair.			the DNS and/or designee will	be	
	CNA #5 indicated at the time that she				responsible for daily	-11	
	did know the resident was to have a				environmental inspections on shifts of all resident rooms and		
	dycem in his wheelchair. She further				equipment. This audit will ens		
	indicated she h	nad laid him down after			all safety and fall prevention		
		ange his brief and then			interventions are in place and		
		ck into the wheelchair.			properly being utilized. A nurs	sing	
	piacca min ba	on this the wholehall.			in-service will be held on or		
	The record for	Resident #36 was			before 12/5/12. The		
					DNS/designee is responsible		
		0/31/12 at 8:57 a.m.			conducting this in-service. The in-service will review the facility		
		diagnoses included,			policy titled, "Fall Managemen	•	
		mited to, cataracts, high			Program". This in-service will		
	blood pressure				also include review of the care		
	osteoarthritis,	chronic pain syndrome,			plan process and importance	of	
	depressive dis	order, and amputation			adherence to established care	•	
	of his arm.				plans and safe practices in		
					regards to safety interventions		
	Review of Phy	sician Orders dated			such as positioning devices in wheelchairs and leaving resid		
	_	ated to utilize a broda			unattended in rooms. What	Cillo	
		positioning and			measures will be put into pla	ace	
		ner Physician Order			or what systemic changes w		
		2, indicated to add			be made to ensure that the		
					deficient practice does not		
	dycem to the v	vneeichair.			recur: A nursing in-service wi		
					held on or before 12/5/12. Th		
		quarterly 10/1/12			DNS/designee is responsible		
	Minimum Data	• •			conducting this in-service. The in-service will review the facility		
	assessment in	dicated the resident			policy titled, "Fall Managemen		
	was not alert a	ind oriented. He			Program". This in-service will		
	needed extens	sive assist with a two			also include review of the care		
	person physica	al assist for bed			plan process and importance	of	
		ers, personal hygiene,			adherence to established care	9	
	•	The resident also had			plans and safe practices in		
	a history of falls.				regards to safety interventions		
		.			such as positioning devices in wheelchairs and leaving resid		
	Dovious of the	10/1/12 fall riok			unattended in rooms. In addit		
	Review of the	10/1/12 fall risk			anationada in rooms. In addit		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155115	A. BUI B. WIN			11/05/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LASALLE AVE		
CAPDIN	AL NILIDSING AND	REHABILITATION CENTER			I BEND, IN 46617		
	- HONOING AND	REHABILITATION CENTER		300111			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assessment indicated the resident				the DNS and/or designee will I	oe	
	was at risk for	falls.			responsible for daily	.II	
					environmental inspections of a resident rooms and equipment		
	Review of the	fall screen completed			all shifts. Any change in resident		
	by the Occupa	•			safety needs will be identified	0111	
		ted 10/25/12, indicated			during daily clinical meetings.		
	•	eeds a hoyer lift times			Changes will be communicate	d	
		ransfer. The resident			by the Nurse Management		
		ad three falls in the last			Team/designee to direct care		
					staff promptly through updates	s to	
		as positioned in a			care plans and Nurse Aide Assignment Sheets. How the		
	1 -	hair. The resident will			corrective action(s) will be		
	•	in broda chair to			monitored to ensure the		
	improve comfo	ort and positioning.			deficient practice will not red	eur.	
					i.e., what quality assurance	,	
	Review of the	current plan of care			program will be put into place	e:	
	dated 2/25/11,	and updated on			To ensure compliance with the	ese	
		ated the resident was			corrective actions, the		
		due to impaired			DNS/designee will complete the	ne	
		ty, stroke, tends to fall			CQI Audit Tool titled, "Fall Management" daily for 3 week		
		elchair and will refuse to			weekly for 6 months. If thresh		
	=	es down in bed/chair,			of 90% is not met, an action pl		
	1				will be developed. Findings w		
	_	and had a history of			be submitted to the CQI		
	_	bed. The Nursing			Committee for review and follo	w	
		ere to asses the			up. By what date the system	ic	
		he was tired, therapy			changes will be completed:		
	screen for a wl	neelchair, offer resident			Compliance Date: 12/5/12.		
	pajama pants,	a scoop mattress,					
	extra long high	low bed to be kept in					
	lowest position	-					
		wheelchair in his room,					
		n the wheelchair.					
		. a.o miodionali.					
	Review of Nurs	sing Progress Notes					
		2 at 10:50 p.m.,					
	indicated the re	esident was found on					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
NAME OF I			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIEF	· ·		1121 E	LASALLE AVE		
		REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		up on the floor mat at					
		bed alarm was					
		the CNA went into the					
		d the resident on the					
	floor. The resident indicated he was getting up to get some pants from the closet.						
	The next docu	mented fall was on					
	10/24/12 at 8:0	00 p.m., which indicated					
	the resident ha	ad fallen out of bed.					
	The resident w	as observed sitting on					
	his knees on th	ne floor mat next to the					
	bed.						
	Nursing Progre	ess Notes dated					
		00 a.m., indicated the					
		itting up in a wheelchair					
		oom eating a snack					
		ed to this right side and					
		floor on his right side.					
		in the dining room					
		lent fell but could not					
	get to him quic	rk enougn.					
	Interview with t	the Third Floor Unit					
		0/31/12 at 2:00 p.m.,					
		lycem had not been					
		chair because it was a					
	new chair for the						
	i new chall lot li	iie iediueiil.					
	Interview with [.]	Third Floor Unit					
		1/2/12 at 3:00 p.m.,					
		esident should not be					
	i leit alone in his	s room due to his high					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00	11/05	SURVEY LETED 5/2012
	ROVIDER OR SUPPLIER AL NURSING AND REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP COE LASALLE AVE I BEND, IN 46617	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	risk for falls, and he should have a dycem in his wheelchair all the time.				
	3.1-45(a)(2)				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 11/05/2012
		155115	B. WING		11/05/2012
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
CARDINA	AL NURSING AND	REHABILITATION CENTER		E LASALLE AVE TH BEND, IN 46617	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	, and the second	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0325 SS=D	UNAVOIDABLE Based on a reside assessment, the resident - (1) Maintains acc nutritional status, protein levels, unicondition demons possible; and (2) Receives a the a nutritional probl Based on obse and interview, for eacceptable par related to supp ordered for one of weight loss a low protein level reviewed for nutresidents who in nutrition. (Resident #31 with dining room eat that time, the re pureed diet. The carton of chocol an orange drint	crvation, record review, the facility failed to sident maintained the ameters of nutrition lements given as a resident with a history and one resident with els for 2 of 3 residents utrition of the 6 met the criteria for ident #31 and #137) e: 2 at 12:25 p.m., was observed in the ting his lunch meal. At esident was served a ne resident had a olate milk and cup of k. There was no can of her cup with the	F0325	F325 – Maintain Nutrition Status Unless Unavoidable the intent of this provider to ensure that each resident (1 maintains acceptable param of nutritional status, such as weight and protein levels un the resident's clinical conditi demonstrates that this is no possible; and (2) receives a therapeutic diet when there nutritional problem. What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice: Resident #31 – ha experienced no further weig loss and has been receiving physician ordered suppleme well as fortified mashed pota with lunch and supper. The physician and the responsib party were made aware of the resident's current nutritional status. Resident #137 – has experienced no weight loss lab values are within normal limits. He has been receiving	eters body less on t is a een as ht the ent as atoes le nis

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLETE	D
		155115	A. BUII		-	11/05/201	12
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R					
CADDINI		DELIABILITATION CENTED			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		30011	I BEND, IN 46617		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CC CC	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		12:50 p.m., the			physician ordered cottage che		
resident was observed eating his				at all meals. The physician ar the responsible party were ma			
	lunch in the di	ning room. The			aware of this resident's currer		
	resident was s	erved a pureed lunch			nutritional status. <i>How other</i>		
	that consisted	of broccoli, noodle			residents having the potenti		
ı	casserole, a b	readstick, and a			to be affected by the same		
ı	·	resident did not receive			deficient practice will be		
		ed potatoes. The			identified and what corrective	⁄e	
		-			action(s) will be taken: Any		
	resident was served a carton of chocolate milk and glass of fruit				resident with orders for		
					supplements or nutritional enhancements have the poter	atiol	
	punch. The resident did not receive				to be affected by this finding.		
	any Ensure su	ppiement.			DNS/designee will be respons		
					for completing a facility audit t		
		the resident at that			review all residents with physi	cian	
	time, indicated	sometimes he gets the			ordered supplements and/or		
	ensure someti	mes he does not.			dietary recommendations for		
					nutritional enhancements such		
	Interview with	Dietary Aid #1 on			cottage cheese or lactose free milk. These orders will then be		
	11/1/12 at 12:	58 p.m., indicated she		compared to each resident's			
		the resident was to			dietary card and Nurse Aide		
		tified mashed potatoes.			Assignment Sheet. Any		
		dicated everyone who			discrepancies noted will be		
		oods also gets the			clarified and corrected at that		
	~	<u> </u>			time. The daily Dining Room		
	regular entree	as well.			Supervisor assigned to each		
	The mercural f	Desident #04 ···-			dining room for each meal will monitor that physician ordered		
		Resident #31 was			supplements and nutritional		
		0/31/12 at 1:59 p.m.			enhancements are provided a	s	
		diagnoses included,			ordered and noted on each		
		mited to, anemia,			resident's dietary card. An all		
	osteoarthritis,	chronic renal failure,			staff in-service will be held on	or	
	stroke, and ora	al cancer.			before 12/5/12. The	for	
					DNS/designee is responsible		
	Review of the	Physician's Orders			conducting this in-service. The in-service will include review of		
		vith the original order			the policy related to Weight	′'	
		2, indicated the resident			Management and supplement		
	4410 01 0/22/ 12	-, maioatoa trio resident]		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B∐	ILDING	00	COMPLETED
		155115	B. WI			11/05/2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				LASALLE AVE	
	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG		LSC IDENTIFYING INFORMATION)		TAG		5.112
	was to receive	Ensure Plus eight			and nutritional enhancement u	
ounces, 1 can at meals.				Any physician order or dietary		
					changes will be reviewed and updated during daily clinical	
	Review of Dieta	ary Progress Notes			meetings. What measures w	ill
		indicated the resident			be put into place or what	""
	•	fortified mashed			systemic changes will be ma	nde
		unch and supper.			to ensure that the deficient	
	Polatoes Will It	and and supper.			practice does not recur: An a	all
	Daview of the				staff in-service will be held on	or
		weight record indicated			before 12/5/12. The	
		esident weighed 129			DNS/designee is responsible	
	-	/12 the resident			conducting this in-service. Th	
	weighed 125 p	ounds, on 9/6/12 the			in-service will include review of)T
	resident weigh	ed 127 pounds, on			the policy related to Weight Management and supplement	
	1	ident weighed 125			and nutritional enhancement u	
		9/12 the resident			In addition, the daily Dining Ro	
		ounds, on 10/16/12 the			Supervisor assigned to each	
		ed 117 pounds and on			dining room for each meal will	
	_	•			monitor that physician ordered	
		esident weighed 118			supplements and nutritional	
	pounds.				enhancements are provided a	S
					ordered and noted on each	
		ad a significant weight			resident's dietary card. Any	
	loss from 9/17/	12 to 10/24/12 of			physician order or dietary changes will be reviewed and	
	seven pounds	and 5.9%.			updated during daily clinical	
					meetings by the Nurse	
	Review of Dieta	ary Progress Notes by			Management Team/designee.	
		etary Manager dated			How the corrective action(s)	
		ted the a nutrition risk			will be monitored to ensure	the
	•	as completed. The			deficient practice will not red	cur,
		•			i.e., what quality assurance	
		dicated the resident's			program will be put into place	
	1	was 125 pounds and			To ensure ongoing compliance	
		eight. The note			with these corrective actions, to DNS/designee will complete the	
	addressed the	resident was below his			CQI Audit Tool titled,	IC
Body Mass Index (BMI) and has had				"Supplement" daily for 3 week	s	
		weight loss. No			weekly for 6 months. She will	
	1	ons were made at that			be responsible for completion	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155115		LDING		11/05/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CADDINI	AL NILIDOINIC AND	DEHABILITATION CENTER			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		30011	I BEND, IN 46617		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	time.				the CQI Audit Tool titled, "Die		
					Recommendations" weekly fo		
	The next Dietary Note was a Nutritional at Risk review dated			weeks and monthly for 6 months. If threshold of 90% is not met, an			
					action plan will be developed.	, all	
	9/7/12. which i	ndicated the resident			Findings will be submitted to t	he	
		chemotherapy and			CQI Committee for review and		
	1	resident's weight had			follow up. By what date the		
		le at this time. No			systemic changes will be		
		ons were made.			completed: Compliance Date	::	
		ons were made.			12/5/12.		
	The second of second	manufad Dietem					
		mented Dietary					
	. •	was by the Registered					
	, ,	dated 9/17/12. The					
	RD noted a ch	ange in condition with					
	the resident. S	She indicated his food					
	consumption v	vas poor and he was					
	still receiving t	reatment for his oral					
	1	RD indicated his weight					
		2-9/12 was 124-129					
		ecommendations were					
	made at that ti						
	i illaue at tilat ti	ille.					
	Thoma	other DD programs					
		other RD progress					
	notes in the re	sident's clinical record.					
		12 plan of care					
		esident had the					
	potential for al	teration in nutrition					
	related to bein	g on a mechanically					
	altered and the	erapeutic diet. The					
		ved supplements to help					
		al needs. The Nursing					
		ere to provide adaptive					
	1	-					
		ovide supplements per					
	Physician orde	ers, monitor weights and					

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Event ID: 10ZI11

Facility ID: 000048

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155115	B. WIN		·	11/05/	2012
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	•		1121 E	LASALLE AVE		
		REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFELENCTY		DATE
	the Physician a	nt weight changes to and family.					
	indicated she v	RD visits to the facility was there on 9/20, 3, 10/10, 10/16, and					
	on 11/1/12 at 8 resident had no since 9/17/12. the facility held night on 10/31/2 resident's curre Director of Nur should have be	the Director of nursing 8:10 a.m., indicated the ot been seen by the RD She further indicated I a NAR meeting last 712 to discuss the ent weight loss. The sing indicated the RD een notified earlier of weight loss from					
	on 11/1/12 at 2 Ensure supple units by the die	the Director of Nursing 2:00 p.m., indicated the ment was sent to the etary department and resident's trays.					
	Food Manager p.m., indicated supplement wa food trays during dietary. She fuwas unaware t	as to be placed on the ng the meal times from urther indicated she he resident was e receiving fortified					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155115	B. WING		11/05	/2012
NAME OF D	PROVIDER OR SUPPLIE	D.	STRI	EET ADDRESS, CITY, STATE, ZIP	CODE	
				1 E LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER	SO	JTH BEND, IN 46617		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
1	2 Pesident #1	37 was observed on				
		29 a.m., in his bed. The				
	resident had just received his breakfast tray. He was served 8 ounces of 2% milk (not lactose free), 2 bowls of hot cereal, eggs, sausage and grapefruit slices. He was not served cottage cheese.					
	serveu collage	5 G1555.				
	On 10/31/12 a	t 12:40 p.m., the				
		is lunch tray, he did not				
	receive cottage	,				
	On 11/1/12 at	12:45 p.m., the				
		eating lunch, he was				
		li, ambrosia, garlic				
		cken with spaghetti				
		resident did not receive				
	cottage chees	e.				
	Ĭ					
	The resident w	as in the Main Dining				
	Room on 11/2	/12 at 8:48 a.m. He had				
	his breakfast t	ray. He was served				
	lactose free m	ilk, sausage and				
	biscuit, 2 bowl	s of hot cereal and 2				
	boiled eggs. T	here was an eight				
	ounce carton o	of 2% milk on his tray.				
	There was no	cottage cheese served				
	to the resident	. The Speech				
	Language Pat	hologist was seated				
	next to the res	_				
		1/2/12 at 10:35 a.m.,				
	with the Speed	ch Language				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155115	B. WIN	G		11/05/2012
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>		1121 E	LASALLE AVE	
	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		dicated the resident				
		neese. She indicated				
		ved cottage cheese				
		ast on 11/2/12. She				
		ne had a glass of milk				
	and a carton of	milk.				
	The record for	Resident #137 was				
		0/31/12 at 9:06 a.m.				
		ad diagnoses that				
		rere not limited to, end				
	stage renal dis					
	_	The resident received				
	dialysis three ti					
	dialysis tillee ti	mes per week.				
	The plan of car	e from the dialysis				
	•	20/12 indicated the				
	resident was to	receive dialysis three				
		x. The goals as of				
	9/20/12 were:	3				
		of protein in the body)				
	, , ,	or more. The current				
	level was 2.6					
		electrolyte in the				
	' '	e 3.8-5.5. The current				
	level was 4.9	o.o o.o. The duridit				
		mineral in the body)				
		5. The current level				
	was 4.6.	o. The durient level				
		neral in the body) level				
	,	the current level was				
	9.8.	LITE CULTELL IEVEL WAS				
	ə.o.					
	There was a ca	are plan dated 10/30/12				
	that indicated:	,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155115	B. WING			11/05/	2012
NAME OF P	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	BEND, IN 46617		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE)		DATE
		teration in nutrition					
	related to resident requires therapeutic diet related to end stage renal disease, hypertension and						
		* •					
	receives dialysis. Some of the interventions included:						
		l at breakfast, cottage					
		_					
	cheese three times a day and Nepro -monitor weight						
	-diet per physi						
	There was a Physician Order dated						
		indicated to add					
		e 1/4 cup TID (three					
	times a day), a	add double supercereal					
	at breakfast ar	nd lactose free milk (soy					
	or rice milk Ok	() for nutritional					
	problem.						
		resident's lab results					
	dated 10/9/12,						
		ium level was 9.8,					
	l ,	limits) and the					
	resident's albu	ımin level was 2.5 (low).					
	The area server as						
	·	rogress note dated					
		en by the Registered					
	· ·	indicated the resident					
		o twice daily, 1/4 cup of e, double supercereal					
	and lactose fre	•					
	anu iaciose ire	C IIIIK.					
	Interview with	the Nurse Consultant					
		2:35 p.m., indicated the					
		d not have been served					
	I resident shoul	u not nave been served					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/05/2012
	PROVIDER OR SUPPLIE IAL NURSING AND	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	2% milk. She i receive lactose	ndicated he was to e free milk.			
	on 11/5/12 at 8 physician had cheese to imp calcium and prindicated the control of the control o	the Director of Nursing 3:18 a.m., indicated the ordered the cottage rove the resident's rotein levels. She cottage cheese should en as ordered by the			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155115	A. BUII B. WIN			11/05/	2012
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			LASALLE AVE		
CADDINI	AL NITIDGING AND	REHABILITATION CENTER			BEND, IN 46617		
CARDINA	AL NORSING AND	REHABILITATION CENTER		300111	1 BEND, IN 40017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329 SS=D	483.25(I) DRUG REGIMEN UNNECESSARY						
		rug regimen must be free					
	from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications						
		ne presence of adverse					
		hich indicate the dose					
	•	ed or discontinued; or any					
	combinations of t	he reasons above.					
	resident, the facil residents who had drugs are not give antipsychotic drug treat a specific co documented in th	orehensive assessment of a ity must ensure that ve not used antipsychotic en these drugs unless g therapy is necessary to ondition as diagnosed and the clinical record; and e antipsychotic drugs					
		lose reductions, and					
		entions, unless clinically n an effort to discontinue					
	Based on reco	rd review and	F03	29	F329 – Drug Regimen Is Free		12/05/2012
		acility failed to ensure	103	<i>,</i>	From Unnecessary Drugs It is		12/03/2012
	-	drug regimen was free			the intent of this provider that		
		ary drugs for 3 of 10			each resident's drug regimen t	ре	
		wed for unnecessary			free from unnecessary drugs.		
		o having a diagnosis to			What corrective action(s) will	l	
	_	e of an anti-psychotic			be accomplished for those residents found to have been	,	
	• •	onitoring the apical			affected by the deficient	•	
	pulse prior to g				practice: Resident #68		
					–physician has been notified o	f	
		d monitoring elevated			past and recent accucheck		
		Residents #15, #68,			results and any accucheck res	ults	
	and #84)				outside the physician ordered parameters. This resident		
					experienced no negative outco	me	

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	ETED
		155115	B. WIN			11/05/2	2012
			Б. WП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	de:			related to this finding. Resider	nt	
					#15 – physician has been noti	fied	
	1 The record	for Resident #68 was			of resident's pulse and blood		
		0/31/12 at 2:07 p.m.			pressure. Resident's apical p		
					is being obtained and recorde	d	
		diagnoses included,			prior to giving Digoxin. This	tivo	
		mited to, diabetes and			resident experienced no nega outcome related to this finding		
	behavior distu	rbance.			Resident #84 – physician has		
					been notified related to use of		
	Review of the	10/12 Physician's			Seroquel and clarification order		
	Order Summa	ry (POS), indicated the			have been obtained regarding		
	resident receiv	ved 14 units of Humulin			updated diagnosis. How othe	r	
		wice daily. On 10/31/12,			residents having the potential	al	
		reduced to 7 units twice			to be affected by the same		
	daily.	reduced to 7 units twice			deficient practice will be		
	ually.				identified and what correctiv	е	
					action(s) will be taken: Any		
	_	order dated 5/30/12 and			resident with orders for		
		nt on the 10/12 POS,			accuchecks, orders to obtain a	and	
	indicated the r	esident was to receive			record vital signs prior to medication administration and	/or	
	accuchecks (a	test to monitor the			orders for psychotropic	/01	
	blood sugar) tv	wice a day at 7:00 a.m.			medications is at risk to be		
	and 4:00 p.m.	The Physician was to			affected by this finding. A faci	lity	
	•	blood sugar was			audit will be conducted by the		
	greater than 2	_			Nurse Management Team. T		
	J. 52.13. 1.10.1 2				audit will review all residents v	vith	
	Deview of the	August September			physician's orders for:		
		August, September,			accuchecks, obtaining and		
		012 Blood glucose			recording vital signs prior to medication administration and		
	_	eets, indicated the			residents with orders for		
		d sugar was above 200			psychotropic medications. Th	e l	
	on the followin	g dates and times,			Nurse Management Team will		
	however, the r	esident's physician was			then review clinical records to		
	not notified as	ordered:			ensure documentation is pres		
					and recorded as ordered, that		
	8/6 4:00 n m	blood sugar 256, 8/25			physician's have been notified	of	
	-	od sugar 216, and			any accuchecks outside the	_,	
		_			notification parameters and th		
	1 0/29/12 4.00 p	.m., blood sugar 214.			all psychotropic medications h	lave	

i ´		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155115	B. WING		11/05/2012
		<u> </u>		ADDRESS, CITY, STATE, ZIP COD	_ E
NAME OF P	ROVIDER OR SUPPLIE	R		E LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER		H BEND, IN 46617	
				1	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT ACTION SHOULD	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ROPRIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				an appropriate diagnosis	
	9/8 4:00 p.m.,	blood sugar 244, 9/9		support the use. The Nu	
	4:00 p.m., bloc	od sugar 271, 9/12 4:00		Management Team will b	
	•	gar 238, and 9/23/12		responsible for daily revie	
	4:00 p.m., bloc	_		MARs and Blood Glucose Monitoring Records to en	
	- .ου μ.π., μιου	ougai 201.		vital signs have been obta	
	40/00 : 55			and recorded prior to med	
		n., blood sugar 238 and		administration and physic	
	10/23/12 4:00	p.m., blood sugar 208.		have been notified for acc	
				results outside the ordere	
	Interview with	the Assistant Director		parameters. In addition,	
of Nursing on 11/2/12 at 9:40 a.m.,				Nurse Management Tean	n will
	indicated the physician should have			monitor all new orders for	-
	•	f the resident's blood		psychotropic medications	to
				ensure thorough and com	
		ater than 200 as		documentation is present	
	ordered.			as an appropriate diagno	sis to
				justify the need for the	
	2. The record	for Resident #15 was		medication. Orders will b	
		0/31/12 at 9:33 a.m.		corrected and clarified as	
		diagnoses included,		needed. A mandatory nu	-
		_		in-service will be conduct the DNS/designee on or I	
	but were not li	-		12/5/12. This in-service v	
	Tibriliation (an i	rregular heartbeat).		include review of the facil	
				titled, Medication Adminis	
	A Physician's o	order dated 5/25/12 and		Procedure including obtain	
	identified as cu	urrent on the October		and recording vital signs	_
	2012 Physicia	n's Order Summary		specific medication	
	_	ed the resident was to		administration, Blood Glu	
		n (a heart medication)		Monitoring with physician	
	_	•		notification when appropr	iate and
	_	ns (mg) by mouth daily.		Psychoactive Medication	
	_	as to be held if the		Management Program.	_
	,	olic blood pressure (top		staff will be re-educated r	
	number) was l	ess than than 60 and		clinical justification for use	
	the resident's r	oulse was to be		psychoactive medication as required and appropria	
	checked.			supportive documentation	
	2			measures will be put int	
	Review of the	Octobor 2012		or what systemic change	-
1	KEVIEW OF THE	UCIODAL ZUTZ	1	I OI WHAL SYSTEIIIL CHAILY	GO WILL

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155115	B. WIN			11/05/2012
NAME OF P	DOMDED OF GUIDNI 150			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	•		1121 E	LASALLE AVE	
		REHABILITATION CENTER		<u> </u>	BEND, IN 46617	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE
		ministration Record			be made to ensure that the deficient practice does not	
	, ,,	ed there was no pulse			recur: A mandatory nursing	
	•	fior to giving the			in-service will be conducted by	,
		the following dates:			the DNS/designee on or befor	•
		3, 10/9, 10/11, 10/12,			12/5/12. This in-service will	
	10/13, 10/14, 1	0/17, 10/18, 10/19,			include review of the facility po	- I
	10/22, 10/23, 1	0/24, 10/26-10/29, and			titled, Medication Administration	•
	10/31/12.				Procedure including obtaining	•
					and recording vital signs prior specific medication	10
	The Septembe	r 2012 MAR, indicated			administration, Blood Glucose	
	•	ocumented on 9/3,			Monitoring with physician	
	•	4, 9/24 and 9/25/12.			notification when appropriate a	and
	0, 11, 0, 10, 0, 1-	1, 3/2-1 dild 5/20/12.			Psychoactive Medication	
	Paviaw of the	August 2012 MAR,			Management Program. Nurs	
		_			staff will be re-educated regard	_
	·	ulse was documented			clinical justification for use of a psychoactive medication as w	
	UN 8/8, 8/9, 8/1 	0, 8/22, and 8/23/12.			as required and appropriate	CII
		la a Assistant Di			supportive documentation. Th	ne
		he Assistant Director			Nurse Management Team will	•
	_	1/2/12 at 9:45 a.m.,			responsible for daily review of	
		esident's apical pulse			MARs and Blood Glucose	
		een checked and			Monitoring Records to ensure vital signs have been obtained	
	•	ior to giving the			and recorded prior to medicati	
	_	rther indicated a			administration and physicians	
	clarification ord	ler needed to be			have been notified for accuche	eck
	obtained relate	d to the resident's			results outside the ordered	
	blood pressure	parameters.			parameters. In addition, the	
	·				Nurse Management Team will	
	3. The record for	or Resident #84 was			monitor all new orders for psychotropic medications to	
		0/31/12 at 8:44 a.m.			ensure thorough and complete	
		diagnoses included,			documentation is present as w	
		nited to, dementia and			as an appropriate diagnosis to	
	anxiety.	into to, domentia and			justify the need for the	
	annicty.				medication. How the correcti	
	Λ Dhyoioian's a	order dated 0/12/12			action(s) will be monitored to	
		order dated 9/12/12,			ensure the deficient practice	
	indicated the re	esident was to receive			will not recur, i.e., what quali	ty

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/05/2012	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	1121 E	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN 46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE
	mouth daily. The have a diagnost of the Seroque Interview with to on 11/5/12 at 2 resident had be medication at had diagnosis wo	milligrams (mg) by ne resident did not sis to support the use		assurance program will b into place: To ensure ongo compliance with this correct action, the DNS/designee of monitor all new orders for psychotropic medications the ensure thorough and complete documentation is present as an appropriate diagnosity justify the need for the medication. The DNS/des will also be responsible for completion of the CQI Aud titled, "Unnecessary Medicand "Blood Glucose Monitor weekly for 4 weeks, then infor 6 months. In addition, the DNS/designee will be resported for completion of the CQI Aud Tool titled, "Medication Administration Record Review Weekly for 4 weeks, then infor 6 months. If threshold is not met, an action plan of developed. Findings will be submitted to the CQI Complete to the CQI Complete Compliance date = 12/5/12	oring ctive will co clete as well s to ignee it tools cations" coring" nonthly he onsible Audit view" nonthly of 90% vill be e mittee ay d:

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Event ID: 10ZI11

Facility ID: 000048

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	DDIC	00	COMPL	ETED
		155115	1	LDING		11/05/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R					
CABDINI	AL NITIDGING AND	REHABILITATION CENTER			LASALLE AVE I BEND, IN 46617		
	AL NURSING AND	REHABILITATION CENTER		30011	1 BEND, IN 40017		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0369	483.35(g)	#050 54TNO					
SS=D		/ICES - EATING					
	EQUIPMENT/U						
		provide special eating provide special eating					
	need them.	densits for residents who					
		ervation, record review,	F03	69	F369 – Assistive Devices –		12/05/2012
		the facility failed to	103	0)	Eating Equipment/Utensils It	is	12/03/2012
		esident received			the practice of this provider to		
					provide special eating equipm		
		oment to facilitate their			and utensils for residents who		
	•	with eating related to a			need them. What corrective		
		1 of 3 residents			action(s) will be accomplished	ed	
	reviewed for n	utrition of the 6			for those residents found to		
	residents who	met the criteria for			have been affected by the		
	nutrition. (Res	sident #36)			deficient practice: Resident #	‡36	
					- has been receiving his	s al	
	Findings inclu	de:			specialized drinking cup at me times. This resident experience		
					no negative outcome related t		
	1 On 10/31/1	2 at 12:16 p.m.,			this finding. How other		
		was observed in the			residents having the potentia	al	
		raiting on his lunch tray.			to be affected by the same		
	_	,			deficient practice will be		
		nad three regular cups			identified and what correctiv	е	
		nilk, thickened juice, and			action(s) will be taken: Any		
		er placed in front of him.			resident with recommendation	_	
	The resident r	eceived his lunch tray			for use of specialized adaptive	9	
	at 12:41 p.m.	At that time there were			equipment, assistive devices and/or specialized eating uten	oilo	
	no nosey cups	s given to him to drink			has the potential to be affected		
	from. The res	ident started to feed			this finding. The DNS/designe		
	himself and w	as observed to drink			will be responsible for comple		
	from the regul	ar plastic cups. The			a facility audit. This audit will	-	
	_	erages were not placed			review all residents with		
		os during this meal.			recommendations for specialize		
	into nosey cup	o daming tine meal.			adaptive equipment, assistive		
	Om 44/4/40 =±	10:10 m m th -			devices and/or specialized ear	ung	
		12:40 p.m., the			utensils. This information will then be compared to each		
		observed in the dining			resident's care plan and the		
	I room eating hi	is lunch. The resident			Tooluchit a care plan and the		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONS	STRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		_	00	COMPL	ETED
		155115	A. BUILDING	j		11/05/	2012
			B. WING	DEET AD	DRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CADDIN	AL NUIDOINO AND	DELIADU ITATION CENTED			ASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER	50	UIHE	BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC		DEFICIENCY)		DATE
	had three regu	lar cups of beverages			Nurse Aide Assignment Sheet		
	in front of him.	The resident did not			Any discrepancies will be clarif		
	receive any no	sey cups for his drinks.			and corrected at that time. The	е	
		vas observed drinking			daily Dining Room Supervisor assigned to each dining room	for	
	from the regula				each meal will monitor that	101	
	nom the regular plastic caps.				specialized assistive devices,		
	At that time, the Consultant Dietary				eating equipment and utensils	are	
	At that time, the Consultant Dietary				utilized as recommended. Any		
	_	r, indicated the adaptive			changes related to specialized	l	
	equipment is brought up to the dining				adaptive equipment, assistive		
	room from the kitchen and it was the				devices and/or specialized eat	ing	
	responsibility of the Nursing staff to				utensils will be reviewed and		
	pour the beverages into the nosey				updated during daily clinical	a	
	cups for the re	sident.			meetings. A mandatory nursing in-service will be conducted by	-	
					the DNS/designee on or before		
	The record for	Resident #36 was			12/5/12. This in-service will	C	
		0/31/12 at 8:57 a.m.			include review of the facility po	olicy	
					related to use of adaptive	•	
		diagnoses included,			equipment, assistive devices a		
		mited to, dysphagia			specialized eating equipment a		
	•	owing), dementia, and			utensils for residents who need		
	esophageal re	flux.			them. Staff will be re-educated		
					regarding the importance of us	se	
	Review of the	current plan of care			of specialized adaptive equipment, assistive devices		
	plan updated 9	9/6/12, indicated the			and/or specialized eating uten	sils	
		potential for alteration			to promote independence and		
		eeds related to receives			ensure that these items are		
		and mechanically		F	provided as recommended.		
		d honey thickened		١	What measures will be put in	ito	
		•		1 -	place or what systemic		
	•	diagnosis of diabetes			changes will be made to		
	and difficulty fo	•			ensure that the deficient		
	_	he nursing approaches			practice does not recur: A	. 20	
	-	e with adaptive			mandatory nursing in-service v	WIII	
	equipment a di	ivided plate and a			be conducted by the DNS/designee on or before		
	nosey cup.				12/5/12. This in-service will		
					include review of the facility po	olicy	
	Interview with	the Second Floor Unit			related to use of adaptive	- J	
			1		•		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155115	B. WIN			11/05/	2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	R			LASALLE AVE		
CADDINI	VI NITIDGING VND	REHABILITATION CENTER			BEND, IN 46617		
CARDINA	AL NORSING AND	REHABILITATION CENTER		300111	1 BEND, IN 40017		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Manager on 11	1/2/12 at 1:09 p.m.,			equipment, assistive devices a		
	indicated the re	esident should have			specialized eating equipment		
	had all of his b	everages placed in the			utensils for residents who need		
	nosey cups.	5 1			them. Staff will be re-educated regarding the importance of us		
					of specialized adaptive	oC	
	3.1-21(h)				equipment, assistive devices		
	J. 1-2 1(11)				and/or specialized eating uten	sils	
					to promote independence and		
					ensure that these items are		
					provided as recommended. T	he	
					daily Dining Room Supervisor	_	
					assigned to each dining room	for	
					each meal will monitor that		
					specialized assistive devices,	oro	
					eating equipment and utensils utilized as recommended. Any		
					changes related to specialized		
					adaptive equipment, assistive		
					devices and/or specialized eat	ing	
					utensils will be reviewed and	Ū	
					updated by the Nurse		
					Management Team/designee		
					during daily clinical meetings.		
					How the corrective action(s)	_	
					will be monitored to ensure t		
					deficient practice will not rec	ur,	
					i.e., what quality assurance		
					program will be put into plac		
					To ensure ongoing compliance with this corrective action, the	=	
					DNS/designee will be respons	ible	
					for completion of the CQI Audi		
					Tool titled, "Accommodation of		
					Needs" daily for 3 weeks and		
					then weekly for 6 months. If		
					threshold of 90% is not met, a	n	
					action plan will be developed.		
					Findings will be submitted to the		
					CQI Committee for review and		
					follow up. By what date the		
					systemic changes will be		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	e survey Pleted 15/2012		
CARDINA		REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETION DATE		
				completed: Compliand 12/5/12.	ce date =			

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Event ID: 10ZI11

Facility ID: 000048

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155115	A. BUI B. WIN			11/05/	2012
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0412 SS=D	483.55(b) ROUTINE/EMER SERVICES IN NF The nursing facilit from an outside re with §483.75(h) o extent covered ur emergency denta needs of each res assist the residen and by arranging from the dentist's refer residents wir dentures to a den Based on obse and interview, t ensure dental e provided for 1 o broken or missi reviewed for de residents who i dental services Findings includ Resident #64 w 10/30/12 at 10: had a broken to portion of her in were in poor co	GENCY DENTAL TS Ty must provide or obtain resource, in accordance of this part, routine (to the rider the State plan); and offices to meet the rident; must, if necessary, out in making appointments; of transportation to and office; and must promptly office; and must promptly office; and must promptly offices and must promptly	F04		F412 – Routine/Emergency Dental Services It is the intent this facility to provide or obtain routine or emergency dental services to meet the needs of each resident and must if necessary, assist the resident making appointments; and by arranging for transportation to and from the dentist's office; a must promptly refer residents of lost or damaged dentures to a dentist. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident # – received dental services on 11/13/12. The family and physician are aware of this resident's oral health status. H other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to	in nd with ed low ee	12/05/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155115 11/05/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1121 E LASALLE AVE CARDINAL NURSING AND REHABILITATION CENTER SOUTH BEND, IN 46617 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG affected by this finding and will be She had diagnoses that included, but identified through a facility audit. were not limited to, dementia with This audit will be completed by behaviors and seizures. She was the DNS/SSD/designee and will admitted to the facility on 12/11/10. review each resident's current oral status. Any resident Review of the medical record identified with difficulty chewing, poorly fitting dentures, sore indicated there was no evidence the mouth or broken/ missing teeth resident had been evaluated by a will be offered immediate dental dentist. services. In addition, all resident clinical records will be reviewed to determine those residents in need Review of the annual Minimum Data of routine dental services. Set (MDS) assessment dated Necessary dental arrangements 1/31/12, indicated the staff was will be made for any resident unable to examine the resident's identified to be in need of routine oral/dental status at the time of the dental services. Any signs of oral health concerns or changes in a assessment. resident's oral/dental status will be identified through daily ADL Interview on 11/2/12 at 4:10 p.m., care by direct care staff including with the MDS Coordinator, indicated teeth brushing and/or during Weekly Nursing Assessments the resident had some broken and and reported timely through daily missing teeth. clinical meetings. Social Services will be responsible for scheduling, Interview with the Social Service monitoring and following up with Director on 11/1/12 at 2:45 p.m., routine dental needs for all residents. An all staff in-service indicated the resident had not been will be conducted by the evaluated by a dentist. She indicated DNS/designee on or before she was not aware that residents 12/5/12. This in-service will were to receive routine dental care. include review of the facility policy related to oral care and dental services. What measures will 3.1-24(a)(1) be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An all staff in-service will be conducted by the DNS/designee on or

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	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00	COMPLETED 11/05/2012	
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
			1121 E LASALLE AVE			
CARDINA	AL NURSING AND I	REHABILITATION CENTER	SOUTH BEND, IN 46617			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				before 12/5/12. This in-service		
				will include review of the facilit policy related to oral care and	-	
				dental services. Staff will be		
				re-educated regarding the		
				process for addressing any or		
				or dental issues identified duri	-	
				routine care. Any signs of ora	I	
				health concerns or changes in resident's oral/dental status w	I	
				be identified through daily ADI		
				care by direct care staff includ		
				teeth brushing and/or during		
				Weekly Nursing Assessments		
				and reported timely through da	•	
				clinical meetings. Social Serv		
				will be responsible for schedul monitoring and following up w		
				routine dental needs for all		
				residents. Customer Care		
				Rounds conducted by		
				Department Leaders will inqui	re	
				with residents/POA regarding		
				satisfaction related to dental services. How the corrective		
				action(s) will be monitored to		
				ensure the deficient practice		
				will not recur, i.e., what quali	I	
				assurance program will be p	- I	
				into place: The		
				DNS/SSD/designee will be	.	
				responsible for completion of t		
				CQI Audit Tool, "Dental Service weekly for 4 weeks and month"		
				for 6 months to ensure this	",	
				finding does not recur. If		
				threshold of 90% is not met, a	n	
				action plan will be developed.		
				Findings will be submitted to the		
				CQI Committee for review and		
				follow up. By what date the		
				systemic changes will be		

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PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155115	(X2) MULTIPLE CO A. BUILDING B. WING	00		LETED 5/2012	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	(X5) COMPLETION DATE	
				completed: Complianc 12/5/12.	e date =		

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Event ID: 10ZI11

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	f '			ľ í	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUIL		00	COMPL: 11/05/		
		133113	B. WING			11/03/	2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE			
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617			
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
F0425	483.60(a),(b)	LSC IDENTIFTING INFORMATION)		IAG			DATE	
SS=D	PHARMACEUTIC PROCEDURES, The facility must persidents, or obtate agreement descripart. The facility personnel to admipermits, but only supervision of a linear permits, but only supervision, and a and biologicals) to resident. The facility must of services of a licer provides consultate provision of pharm Based on obset and interview, the expired medical (Tuberculin) injuresidents who injections after were opened. The first floor. (#139) Findings included the control of the con	provide routine and and biologicals to its in them under an bed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general censed nurse. Povide pharmaceutical g procedures that assure ulring, receiving, administering of all drugs of meet the needs of each employ or obtain the need pharmacist who ution on all aspects of the macy services in the facility. Tryation, record review the facility failed to the did not receive ations related to Aplisol ections for 2 of 4 received the Aplisol the multi dose vials This had the potential idents who resided on Residents #138 and	F04:	25	F425 – Pharmaceutical Services It is the practice of the facility to provide routine and emergency drugs and biologicate its residents and to provide pharmaceutical services (including procedures that asset the accurate acquiring, receiving dispensing, and administering all drugs and biological) to meather needs of each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #138 – has been discharged from the facil Resident #139 - physician and family have been updated	al aure ng, of et I n	12/05/2012	

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	a. Building 00		COMPLETED	
		155115	B. WI			11/05/2012	
			J. ,, 11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			BEND, IN 46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
	•	e two multi dose vials			regarding this resident's curre	nt	
	of Aplisol 5/0.	One of the vials had an			status. The physician and Pharmacist were informed and	1	
	open date of 9/	20/12 and the other			the facility was instructed that		
	vial had an ope	en of 10/3/12.			was not indicated to repeat the		
	<u>'</u>				injection. This resident		
	Review of the	event reports for			experienced no negative outco	ome	
		and #139 indicated the			related to this finding. How ot	l l	
					residents having the potentia		
		ved an injection of the			to be affected by the same		
		e of the multi dose			deficient practice will be		
	vials on 10/26/	12.			identified and what correctiv	е	
					action(s) will be taken: All		
	Review of the	current 7/11 Drug			residents who receive Aplisol		
	Expiration Dati	ng policy provided by			(Tuberculin) injections have th	l l	
		Unit Manager on			potential to be affected by this	l l	
		ted multi dose vials			finding. The Aplisol (Tubercul	•	
	· ·				vials identified in this finding h	ave	
	expired 30 day				been discarded. The DNS/designee will complete a	n	
	l •	er review of the policy			inspection of all medication	"	
		rsol PPD/Aplisol vials			rooms, medication room		
	expired 30 day	s after opening.			refrigerators and medication c	arts	
					to ensure that any opened mu		
	Interview with t	he First Floor Unit			dose vials of medications have	l l	
	Manager on 11	/5/12 at 9:15 a.m.,			appropriate date opened stick		
	_	plisol multi dose vials			in place and are within the dru	g	
		edication room were			expiration date per		
					manufacturer's		
	used for the res	sidents.			recommendations. Any expire	ea	
					medications will be destroyed	ln l	
		he Nurse Consultant			and/or discarded immediately. addition, the DNS/Unit	. 111	
	on 11/5/12 at 1	:26 p.m., indicated			Manager/designee will be		
	there were four	residents who			responsible for facility wide		
	received the A	olisol injections after			weekly medication		
		vere both opened. She			cart/room/refrigerator		
	1	d only two of those			inspections. This will ensure t	hat	
	four residents r	•			all medications are within the		
					drug expiration date per		
	medication afte	er they had expired.			manufacturer's		
					recommendations. A mandat	ory	

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Event ID: 10ZI11

Facility ID: 000048

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	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00 	COMPLETED 11/05/2012		
	PROVIDER OR SUPPLIER AL NURSING AND	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-25(a)			nursing in-service will be conducted by the DNS/designs on or before 12/5/12. This in-service will include review of the facility policy related to medication storage and expirated ates. Nursing staff will be re-educated regarding applying date opened sticker on all multi-dose vials of medications and the importance of checking expiration dates prior to administration of any medications and the assures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory nursing in-service will include review of the facility por related to medication storage as expiration dates. Nursing staff will be re-educated regarding applying a date opened sticked all multi-dose vials of medication the importance of checking expiration dates prior to administration of any medication the importance of checking expiration dates prior to administration of any medication cart/room/refrigerator in spections. This will ensure the land addition, the DNS/Unit Manager/designee within the drug expiration date per manufacturer's recommendations. Any expired medications will be destroyed.	f tion g a s g on. to will blicy and f r on ons g on.		

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Event ID: 10ZI11

Facility ID: 000048

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00 	COMPLETED 11/05/2012	
	ROVIDER OR SUPPLIER AL NURSING AND	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				DNS/designee. How the corrective action(s) will be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place. To ensure ongoing compliance with this corrective action, the DNS/SSD/designee will be responsible for completion of the CQI Audit Tool, "Medication Storage Review" daily for 3 weeks, weekly for 6 months. If threshold of 90% is not met, a action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance date 12/5/12.	e: e the If n	

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
		155115				11/05/	2012
		<u> </u>	B. WING		DDDECC CITY CTATE 7ID CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹	ı		ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	AL NURSING AND	REHABILITATION CENTER			LASALLE AVE BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		AN OUTDING NO. 13 OF GOARD CONTROL		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
F0463	483.70(f)						
SS=D	RESIDENT CALL	L SYSTEM -					
	ROOMS/TOILET	/BATH					
	The nurses' station	on must be equipped to					
	receive resident	calls through a					
		ystem from resident rooms;					
	and toilet and bat	_					
	Based on obse	ervation and interview,	F046	3	F463 – Resident Call System	-	12/05/2012
	the facility faile	ed to ensure the call			Rooms/Toilet/Bath It is the		
	_	nctioning for 1 of 40			practice of this provider that al		
	_	hts checked for			nurse's stations be equipped t		
	function. (Resident				receive resident calls through	а	
	iunction. (Nesi	dent #00)			communication system from		
	e				resident rooms and toilet and		
	Findings includ	ie:			bathing facilities. What		
					corrective action(s) will be		
	The call light fo	or Resident #88, was			accomplished for those residents found to have beer	•	
	observed on 1	1/5/12 at 10:33 a.m.,			affected by the deficient	1	
	during the Env	ironmental Tour. The			practice: Resident #88 – this		
	_	ght had a crack in it.			resident's call light was replace		
		as pressed, but it			immediately with a functional of		
	_	•			light. This resident experience		
		ate the light outside of			no negative outcome related to		
		oom or at the nurses'			this finding. How other		
	station.				residents having the potentia	al	
					to be affected by the same		
	Interview with t	the Administer on			deficient practice will be		
	11/5/12 at 10:3	33 a.m., indicated the			identified and what correctiv	е	
		ot functioning and			action(s) will be taken: All		
	needed to be r	•			residents have the potential to	be	
		opidood.			affected by this finding. The		
	2.4.40/\/4\				ED/Maintenance		
	3.1-19(u)(1)				Supervisor/designee will be		
					responsible for conducting a facility wide inspection of the		
					facility call light system. Each	call	
					light will be tested to ensure	Juli	
					proper function. Any noted		
					issues will be corrected at the		
					time noted. In addition, the fac-	cility	
				l		-	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00	COMPLETED 11/05/2012	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				will conduct Customer Care Rounds/Environmental Inspections daily. These Customer Care Rounds will include checking call light function in resident rooms, bathrooms a bathing areas. A mandatory a staff in-service will be conduct by the DNS/designee on or before 12/5/12. This in-service will include review of the facility policy related to notification to Maintenance Department for repairs or maintenance needs. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: A mandatory all staff in-service who be conducted by the DNS/designee on or before 12/5/12. This in-service will include review of the facility por related to notification to the Maintenance Department for repairs or maintenance needs. The Maintenance Request Process will be reviewed with staff. Staff will be re-educated regarding urgent needs for maintenance such as non-functioning call lights version urgent repair requests. In addition, the facility will conduct Customer Care Rounds/Environmental Inspections daily. These Customer Care Rounds will include checking call light function resident rooms, bathrooms a bathing areas. Any	and II ed ey the to vill licy all d us et	

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Event ID: 10ZI11

Facility ID: 000048

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PRINTED: 11/29/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155115	A. BUILDING B. WING	00 	COMPLETED 11/05/2012	
	ROVIDER OR SUPPLIER AL NURSING AND	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				environmental/repair issues not during Customer Care Rounds will be directed to the Maintenance Department or Housekeeping Department through the Maintenance or Housekeeping Request Proce The ED/designee will review Maintenance Logs/Requests at Housekeeping Request issues ensure all necessary repairs a corrections have been completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualicassurance program will be printo place: To ensure ongoing compliance with this corrective action, the ED/DNS/designee be responsible for directing the Customer Care Rounds/ Environmental Inspections dai for 6 months. If threshold of 9 is not met, an action plan will be submitted to the CQI Committed for review and follow up. By what date the systemic changes will be completed: Compliance date = 12/5/12.	ss. and s to and ve o ty ut g e will e ly 0% oe	

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Event ID: 10ZI11

Facility ID: 000048

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
		155115				11/05/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0465	483.70(h)					•	
SS=C	SAFE/FUNCTION	NAL/SANITARY/COMFOR					
	TABLE ENVIRON	I					
		orovide a safe, functional,					
		nfortable environment for					
	residents, staff ar						
	Based on obse	rvation and interviews,	F04	65	465 –		12/05/2012
	the facility faile	d to ensure the			Safe/Functional/Sanitary/Cor	nf	
	residents' envir	onment was clean and			ortable Environment It is the		
	in good repair r	related to, dust in			intent of this facility to provide	а	
	•	narred and scratched			safe, functional, sanitary, and		
	•	gouged and soiled			comfortable environment for		
		• •			residents, staff and the public.		
	• •	and marred doors,			What corrective action(s) will be accomplished for those		
	• •	ords, loose toilet seat			residents found to have beer		
	rails and toilet t	tissue holder, stained			affected by the deficient	1	
	toilets, stained	caulking and floor			practice: Cottage Unit: Floo	r	
	grout and broke	en tiles. This had the			tiles in bathroom between Roc		
	•	ect 118 of the 118			1 and Room 3 have been	,,,,,	
	•	ing in the facility in 3 of			repaired · Floor tiles and grou	t	
	3 units.	ing in the lability in 6 of			around cove base in bathroom		
		ird Floor and the			between Room 2 and Room 4		
	•	ird Floor and the			have been repaired · Floor tile	es	
	Cottage Unit)				in bathroom between Room 5	-	
					Room 7 have been repaired a		
	Findings includ	e:			the safety rails around the toile		
					have been repaired · Floor tile	es	
	The following w	vas observed during			and rust stains in bathroom between Room 6 and Room 8		
		ntal Tour on 11/5/12 at			have been repaired · Floor tile	20	
		the Administrator, the			around toilet and beneath the		
					in the bathroom between Roor		
		upervisor and the			and Room 11 have been repair		
	Housekeeping	Supervisor:			· Lime build-up around sink di		
					has been removed; rust stains		
	1. On the Cotta	ige Unit:			toilet bowel have been remove	ed;	
					toilet tissue dispenser repaired	t	
	a. The bathroom	m between Room 1			and pull cord replaced in the		
		ad discolored floor tiles			bathroom between Room 16 a		
		board and the caulk			Room 18 · Plaster wall in sho	-	
	מוטווא נווכ שמשכ	board and the cath	1		I room on the Cottage Unit was		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMP			COMPLE	ETED
		155115	A. BUI B. WIN			11/05/2	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
CADDINI	AL AULIDOING AND	DELIADU ITATION CENTED			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		SOUTH	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	around the bas	se of the toilet was			repaired and rust stains remov	/ed	
	discolored. The	ere was a dark black			from shower stalls First Floor:		
		et bowl. 4 residents			Room 128 – bathroom door wa	as	
	used the bathr				repaired Room 115 – walls		
		00111.			cleaned and room chairs repair	ired	
	. <u>-</u>				· Room 118 – room chairs		
		m between Room 2			repaired · Room 106 – room	۱.	
		ad discolored grout			chairs and closet door repaired Room 104 – room repainted; r		
		or tiles along the cove			stains in toilet removed; room	431	
	base. 4 resider	nts used the bathroom.			chair repaired <i>Third Floor:</i>		
					Room 316 – room door repaire	ed	
	c. The bathroo	m between Room 5			· Room 320 – room chairs		
		ad discolored floor tiles			repaired; bathroom door repair	red	
					· Room 324 – room door and		
		seboard. The safety			bathroom door repaired · Roo	m	
		e toilet were loose and			325 – room door repaired ·		
	1	om the wall. 4 residents			Room 327 – room chair repair	ed;	
	used the bathr	oom.			overbed string light repaired · Room 332/Room 333 – bathro	om	
	d The hathron	m between Room 6			door repaired · Shower Room		
					First Floor edging and wall tile		
		ad rust stains on the tile			repaired · All first floor hall ve		
		the toilet. There were			cleaned How other residents		
	red discolored	floor tiles behind the			having the potential to be		
	toilet. 4 resider	nts used the bathroom.			affected by the same deficier practice will be identified and		
					•		
	e. The bathroo	m between Room 9			what corrective action(s) will be taken: All residents have the		
		nad discolored floor			potential to be affected by this		
		e base of the toilet and			finding. All resident rooms,		
		e sink. 4 residents used			bathrooms and bathing areas		
		e sirik. 4 residents used			have been observed for the ite	ems	
	the bathroom.				listed above and all repairs we	ere	
					made where needed. In addit		
	f. The bathroor	n between Room 16			the facility will conduct		
	and Room 18 I	nad a lime build up			Environmental Inspections dai	-	
	around the bat	hroom sink drain.			These Environmental Inspection	ons	
		st stains in the toilet			will include		
		t tissue dispenser was			inspections/observations of		
		•			resident rooms and bathroom	_	
	i ioose. Hiele w	as no pull cord for the			such as floor tiles and bathroo	111	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155115	B. WIN			11/05/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
CADDINI	AL NUIDOING AND	DELIADII ITATION CENTED			LASALLE AVE		
CARDINA	AL NURSING AND	REHABILITATION CENTER		50016	I BEND, IN 46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bathroom call I	ight. 4 residents used			fixtures in need of repair. Any		
	the bathroom.				environmental/repair issues no	oted	
	g. In the shower room, there was a				during these Environmental		
					Inspections will be directed to	the	
	_				Maintenance Department or		
		at had an area that was			Housekeeping Department		
	· ·	inches is size that was			through the Maintenance or	00	
	•	need of repair. The			Housekeeping Request Proce The ED/designee will review	აა.	
	walls of the she	ower stall were stained			Maintenance Logs/Requests a	and	
	a rust color and were in need of				Housekeeping Request issues		
	cleaning.				ensure all necessary repairs a		
	31 residents resided on the Cottage				corrections have been		
	Unit.				completed. A mandatory all st	taff	
	Offic.				in-service will be conducted by	/	
					the ED/DNS/designee on or		
	On the First Flo	oor:			before 12/5/12. This in-service		
					will include review of the facilit		
	a. In Room 128	8, the bathroom door			policy related to notification to	the	
	was gouged ne	ear the upper section of			Maintenance Department		
		idents resided in the			and/Housekeeping Departmer		
	room.				for housekeeping issues, repa or maintenance needs and the		
	100111.				importance of maintaining a	7	
	h In Doom 111	E the well by bed and			safe/functional/sanitary/comfo	rtab	
		5, the wall by bed one			le environment. What measur		
		n food splatter. The			will be put into place or what		
	room chair had	l marred legs and			systemic changes will be ma		
	armrests. 2 res	sidents resided in the			to ensure that the deficient		
	room.				practice does not recur: A		
					mandatory all staff in-service v	will	
	c. In Room 118	3, the room chairs had			be conducted by the		
	marred legs ar	,			ED/DNS/designee on or before	е	
	_	ed in the room.			12/5/12. This in-service will		
	1031001113 10310	CG III UIC 100III.			include review of the facility po	olicy	
		0. Ha a marana ala 11. L			related to notification to the		
		6, the room chair had			Maintenance Department for repairs or maintenance needs		
		its and legs. The closet			and the importance of		
	door had mars	. 2 residents resided in			maintaining a		
	the room and 2	2 used bathroom.			safe/functional/sanitary/comfo	rtab	
					le environment. These		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RUILDING 00		00	COMPLETED	
		155115	A. BUILDING			11/05/2012	
			B. WIN		ADDRESS OVEN STATE SID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
			1121 E LASALLE AVE				
CARDINAL NURSING AND REHABILITATION CENTER				SOUTH BEND, IN 46617			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	e. In Room 104, the wall by the foot of				Environmental Inspections will		
	bed 1 and bed 2 was marred and in			include inspections/obse			
	need of paint. The legs and the				of resident rooms and bathroom		
	armrests of the room chair was			such as floor tiles and bath fixtures in need of repair.			
	scratched and marred. There were			environmental/repair issues			
				during these Environmen).cu	
	rust stains in the toilet. 2 residents			Inspections will be directed		the	
	resided in the room and 4 residents			Maintenance Department of			
	used the toilet.				Housekeeping Department		
					through the Maintenance or		
	On the Third F	oor:			Housekeeping Request Proce	SS.	
					The ED/designee will review		
	a. In Room 316	6, the room door was			Maintenance Logs/Requests a		
	marred and gouged. 1 resident				Housekeeping Request issues		
	resided in the room.				ensure all necessary repairs a	nd	
					corrections have been		
					completed. How the corrective action(s) will be monitored to		
		0, both room chairs had			ensure the deficient practice		
	_	he door on the inside			will not recur, i.e., what quali		
		n was marred. 2			assurance program will be p	-	
	residents resid	ed in the room. 4			into place: To ensure ongoing		
residents used the		the bathroom.			compliance with this corrective		
					action and to ensure the		
	c. In Room 324	1, the inside of the			environment is		
		a 3 inch by 3 foot area			safe/functional/sanitary and		
		ed, the inside of the			comfortable, the		
		,			ED/DNS/designee will be		
	bathroom door had a 2 x 3 inch gouge. Two residents resided in the				responsible for directing the	dit	
					Environmental Inspections Audaily for six months. If thresho		
	room.				of 90% is not met, an action pl		
					will be developed. Findings w		
	d. In Room 325, there were mars on				be submitted to the CQI		
	the inside of the room door. 2				Committee for review and follo	w	
	residents resided in the room.			up. By what date the s		ic	
				changes will be completed:			
	e. In Room 327, the wooden arms of				Completion date = 12/5/12.		
	the room chair were marred and						
	i scratched and	in need of stain or					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/05/	ETED	
NAME OF PROVIDER OR SUPPLIER CARDINAL NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) paint. The string to the overbed light above bed 1 was broken. Two residents resided in the room.			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE		
	and Room 333 of both of the v inside of the ba	om between Room 332 , the bottom 6 inches vooden doors on the athroom were esidents used the						
	_	er Room, the corner by broken edging and 2 es.						
	the unit, had a	y vents in the halls of n accumulation of dust. sided on the Third						
	Supervisor at t	the Maintenance he time of the tour, the above areas were hir or cleaning.						
	3.1-19(f)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 10ZI11

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If continuation sheet

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